DOCUMENT RESUME

ED 377 434 CG 025 856

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TITLE Adolescent Project Pilot for an Outcome Study.
INSTITUTION Washington State Dept. of Social and Health Services, Olympia. Office of Research and Data Analysis.
REPORT NO 4-18a
PUB DATE Feb 92
NOTE 92p.
PUB TYPE Reports - Research/Technical (143)

EDRS PRICE MF01/PC04 Plus Postage.
DESCRIPTORS Adolescents; *Drug Rehabilitation; Elementary Secondary Education; Evaluation Methods; *Feasibility Studies; *Outcomes of Treatment; *Pilot Projects; Protocol Analysis; Rehabilitation; *Research Methodology; *Substance Abuse; Surveys
IDENTIFIERS *Washington

ABSTRACT

This report describes a 7-week pilot study conducted to estimate probable participation rates for a planned substance abuse treatment outcomes study. The pilot program tested whether acceptable response rates might be obtained by contacting clients whose records had been examined by an earlier study (retrospective) or by contacting current clients (prospective). The pilot tested probable contact rates, requirements for travel and time, consent procedures, and the instruments to be used for both retrospective and prospective approaches. The planned outcome study would ask about the adolescents' use of drugs and alcohol and the way adolescents treated for chemical dependency function at home, school, and work. The study would be accomplished through interviews with parents and adolescents, and by examinations of school records, where possible. Results revealed that a prospective model, with follow-along procedures after treatment, was more efficient and effective for an outcome study than was a retrospective model. Consent procedures and consent forms that were developed in the pilot worked well, as did the protocols used for enlisting and training agencies. It was recommended that three instruments used by the pilot program be revised. An appendix contains statistical representations of the findings. Contains 35 references and additional sources. (RJM)

REPORT

ADOLESCENT PROJECT

PILOT FOR AN

OUTCOME STUDY

Washington State
Department of
Social and Health Services
Planning, Research &
Development
Office of Research &
Data Analysis

ADOLESCENT PROJECT PILOT

FOR AN OUTCOME STUDY

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February 1992

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Report 4-18a

ACKNOWLEDGEMENTS

That this project was possible is primarily due to three factors: skilled and experienced interviewers; the agency staff who assisted us in the project; and the pilot respondents, adolescents, parents, and counselors, who were generous in sharing their concerns. We are grateful to them all.

Grateful thanks are given
to the following persons
for their help
in conducting
this study and
producing this report:

Interviewers:

Juli Burkamper
Margaret Knudson
Guy Vance
Gordon Whitlow

Editorial Support:

Dario Longhi
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Margaret Shaklee

Staff Support:

Bonnie Atkinson
Laura Dolinski
Bevin Hansell
Anne Marie Schaefer

TABLE OF CONTENTS

TABLE OF CONTENTS (cont.)

EXECUTIVE SUMMARY

This report describes the findings of a seven-week pilot study. This was conducted to estimate probable participation rates for a planned substance abuse treatment outcome study.

The planned outcome study was to ask about the use of drugs and alcohol and the functioning at home, school, and work of adolescents treated for chemical dependency problems whose treatment was funded by the Division of Alcohol and Substance Abuse (DASA). The outcome study was planned to be done through interviews with parents and adolescents, and by examinations of school records, where possible.

AIMS AND DESIGN OF THE PILOT

The pilot was done to test whether acceptable participation or response rates might be obtained by contacting clients whose records had been examined by an earlier study (a retrospective model) or by contacting current clients (a prospective one). Since current clients could not, by definition, be interviewed a year or more after treatment, a "Mixed" model was added to the prospective and retrospective ones.

The "Mixed" model could be added because one agency had an ongoing parent prospective study, with periodic short telephone interviews of parents, in place for more than a year. For that agency's clients, assessed in early 1990, post-treatment (retrospective) interviews were done with the adolescents, to obtain an estimate of post-treatment response rates for the planned outcome study. The "Mixed" model was parent-prospective and adolescent-retrospective. In this combination model, no parent interviews were conducted, and parent agreements to name release and adolescent interview rates serve as estimates of response rates that might be obtained at the end of a prospective study.

The Pilot for an Outcome Study tested probable contact rates, and requirements for travel and time, in a retrospective treatment outcome study versus such rates and requirements in a prospective outcome study, and in the "Mixed" model where the adolescents were retrospective respondents. The pilot also tested consent procedures and instruments to be used in each approach, with adolescents, parents, counselors, and schools.

Models and Target Populations

The pilot's purpose was to test procedures and instruments for a retrospective versus a prospective treatment outcome study. The retrospective and mixed models had, as target participants, adolescents who were part of the sample from an earlier research study, the Client Descriptive Study. That study sample consisted, in all, of 590 clients assessed for substance abuse treatment between January and May of 1990. The prospective model had, as its target participants, adolescents who began treatment on or after June 1, 1991.

Contact and Consent Procedures

Interviewers made appointments with persons (parents or adolescents) whose names they received from the agencies. They asked first-contact persons for consent to contact the other. In over 80% of cases, agency staff had decided that parents were appropriate first contact persons.

Parents were normally contacted first when the adolescent was under 18 years old. The parents were asked to participate, and then interviewed. They were then asked for permission to contact their adolescents. Adolescents were contacted first if they were 18 or older, or when the treatment agency staff decided they were "special" cases, and that contacting them first would be appropriate.

Contact and Release Rates in Each Model

The retrospective model treatment agencies attempted to reach the 59 of their clients who had been in the earlier descriptive study sample. They succeeded in reaching 18, for a post-treatment "contact rate" of 31%. There were 8 willing to allow name release, so the post-treatment "name release rate" was 44% of the contacted persons.

The "Mixed" model tried to contact 62 of their earlier clients who had been in the descriptive study, and this agency was able to reach 27 (making the "Mixed" contact rate 44%). Nineteen of these agreed to name release, for a post-treatment "name release rate" of 70% of the contacted persons.

This contrast seems to predict a probable increased success of a magnitude of at least one and a half times for the prospective over the retrospective model, considering that the mixed model had an agency prospective study where the parents were involved.

The prospective model in the pilot contacted 18 of their current clients and obtained permission for name release from 12 (66%) of these. [One cannot, by definition, have a "contact rate" in this model in this pilot study, since this model questions clients at the time of the treatment agency intervention (treatment)].

FINDINGS RELATING TO PROCEDURES

Prospective Model Obtained Higher Name Release Rate and Took Less Time

The major finding of the Pilot for an Outcome Study was that the prospective approach resulted in a pre-treatment "name release rate" of 67% of those contacted, while the retrospective model obtained only a 44% post-treatment "name release rate." The prospective model took under an hour per case in agency time and less than seven hours per case in interviewer time. In contrast, the retrospective model took more than two and a half hours per case of agency time, and almost 14 and a half hours per case of interviewer time.

Finally, in the mixed model, which might act as an estimate of the rates to be arrived at in the post-treatment measures of a prospective outcome study, post-treatment "name release rate" was 70% of those contacted, and the post-treatment "interview success rate" was 79% of those contacted. Times required in the mixed model were almost three hours per case for the agency, and six and a half hours per case for the interviewer.

Estimated Time, Travel, and Case Components in the Pilot Study

Travel and time requirements appear to be fairly high for any outcome study in which face-to-face interviews are a key component. Travel comprised over 70% (see
Table 5) of interviewer time in the pilot. One would assume this proportion would be less in a full outcome study, due to economies of scale.

Most respondents were parent-adolescent pairs, with the parent the first contacted and interviewed, except in the "Mixed" model. In that model alone, parents were asked for consent, and permission to contact their children, but were not interviewed. Of the 14 parents interviewed in the prospective and retrospective models, not one wanted to be interviewed with a spouse or significant other.

Of the four "specials" and three over-18-year-olds in the pilot, only one was in the prospective model. Since a prospective study would enroll clients when they were a year and a half younger, one would expect fewer 18-year-olds, and then the majority of cases would be parent-first-contacts.

Agency Involvement and Training were Critical Components of Pilot

Eleven treatment agencies were asked, and eight participated in the study. Agency staff time requirements varied from under an hour per case in the prospective model to about two and a half per case in the retrospective and about three in the mixed model.

Agencies were recruited in individual meetings with the project director. The protocols of the pilot were explained at meetings with the project director and an interviewer. Even so, the meeting at which agency staff were de-briefed at the end of the pilot uncovered a few misunderstandings. This implies that training is a critical component of any outcome study.

FINDINGS RELATING TO INSTRUMENTS

There were two questionnaires that were central to this study: one (about a half hour in length) for parents and one (about an hour long) asked of adolescents. Both were administered in one-on-one interviews, in a place of the respondent's choice, by the pilot interviewers. Generally, these interviews occurred just after the interviewer had explained about the study and the participant had agreed to, and signed, the informed consent.

Other data-gathering tools of the pilot were a short questionnaire (five to ten minutes long) asked of counselors; this was also called the "agency checklist." Finally, there was also a short (one-page) form requesting ten items of information from the schools.

It had been expected that the schools, informed by mail that the pilot was requesting data, would require project staff to gather the data needed, from student files in the schools. All seven of the schools to whom the pilot sent letters responded by completing the forms and returning them by mail.

Proposals for Instrument Revision

Suggestions for revision of all three questionnaires, and the data sheet used to gather information from schools, are noted in this report. Basically, the three instruments all need minor revisions and edits, along with the addition of segments of pre-tested and nationally used instruments to improve comparability with other studies.

Counselors reported considerably more past than present problems in the adolescents' families. They said that 22 of the adolescents came from families with a history of substance abuse, but that only 12 had families with current substance abuse problems. They also reported that 11 came from families with a history of physical abuse, but only one had such a problem in the present. These differences certainly may be real, or they may indicate problems in reporting (not wanting to mention present problems) or in the instrument design (asking about current situations which counselors may not know).

Finally, the school data sheet needs to be modified to allow easier reporting from alternative schools; these, the pilot was informed, commonly use different ways of reporting both grades and attendance from those used in other public schools.

FREQUENCIES OF RESPONSES

Because of the few respondents (30 adolescents and 14 parents), the responses reported here are mostly total responses (prospective, mixed, and retrospective). For a few questions, just retrospective and "Mixed" responses (together) are noted (these are questions that refer to treatment in the past, i.e., the few retrospective-only questions of the adolescent interview.) For a few questions, frequencies are reported by model and by whether the adolescent had completed treatment (or nearly so) or had not completed treatment.

Parent Interview Data

Family Functioning: More than half the 14 parents stated their children were helpful at home, and just over a third said they followed household rules "moderately well."

Use of Drugs or Alcohol: Four of the 14 parents interviewed stated they believe their adolescents used drugs and/or alcohol in the past month.

Completion Comparisons

Although the numbers were too few, and the selection of cases not sufficiently random to make any inferences about data possible, some issues were examined by both model and whether adolescents had completed or nearly-completed at least one treatment program. Responses were tallied for the four groups for a few questions in each of the following areas: recovery, family functioning, support, and how adolescents were getting along in school or at work. Many respondents reported no use in the past month, or only one use (equivalent to a single lapse or "slip").

Adolescent Interview Data

Use of Drugs or Alcohol: Twelve of the 21 adolescents in the retrospective and "Mixed" models stated they had not used drugs and/or alcohol in the past month. Fifteen said they had "a lot more control" over their lives now than in the month after they ended treatment.

Recovery and Support: Eighteen of the 30 respondents said they attended a 12-Step group (like Alcoholics Anonymous, Cocaine Anonymous, or Narcotics Anonymous.) Ten reported doing so at least every other week. Seven respondents said they had a 12-step sponsor, and three reported speaking with their sponsor outside of a meeting, in the past month. Though 14 of the 30 total adolescents reported having family members for whom drug or alcohol use was a problem to themselves or others, none reported attending any of the 12-Step support groups (like Al-anon, Alateen, or Children of Alcoholics) that might assist them with their problems as family members of abusers.

Counselor Interview Data

Treatment Description: Counselors reported 22 of the 30 adolescents interviewed had finished, or nearly completed, at least one prescribed treatment. Nineteen had been treated on an inpatient basis, six on a regular outpatient basis, and one in an intensive outpatient program.

Support in Recovery: According to counselors, at least half of the adolescents had the support of 12-step programs when they left treatment.

Family Problems and Support: Twelve of the 30 said the adolescent's family was involved and supportive before his or her treatment; 17 said the family was involved and supportive during treatment; ten said the family was involved and supportive when the adolescent left or completed treatment.

Comparison with Client Descriptive Data

No case by case comparison has been done to relate the 21 retrospective cases with their records in the Client Descriptive Study data base. A comparison of several responses for the 21 and for the total 590 Descriptive Study persons was done. That short check does not make the two samples look highly comparable, since there are relatively far more Inpatient program treated persons and far fewer single or no parent household represented in the Pilot retrospective cases.

Data from the Schools

Very few schools were contacted about sharing information from their students' files. Those who were, however, responded in writing. There did not seem to be any problem, for them, in sharing data when they had seen the release forms signed by both parent and adolescent. Where there was a difficulty was in obtaining comparable data from alternative schools--which many respondents attended--because their records did not include the same information as that kept by the other middle and high schools. The school data form will certainly require much revision if it is to be included in a later outcome study.

CHAPTER 1: INTRODUCTION

PURPOSE

The primary objective of the Pilot for an Outcome Study was to estimate contact and cooperation rates for participation in a major outcome study, to be done in the future, by adolescents whose treatment for substance abuse was funded by the Division of Alcohol and Substance Abuse (DASA). Both retrospective and prospective models were components of the pilot.

The pilot also specifically intended to attain three other aims: 1) to gain experience in dealing with the practical problems involved in each strategy, 2) to pretest consent forms, procedures, and instruments for interviews of parents and adolescents, and counselors, and 3) to check school records.

Results of the pilot were expected to determine the more appropriate model and the most efficient and effective methods for conducting an outcome study.

PROCEDURES AND METHODS

Two Models, in Separate Agencies

Two models and three interviews were the core processes of the study. The retrospective approach was a model which looked for participants in those who had been assessed a year and a half earlier. Adolescents whose records had been examined for the Client Descriptive Study in late 1990 and early 1991 were the target participants; they had been assessed for substance abuse, and 75% of them were later treated. In the prospective model, current clients of treatment agencies were the target. Thus, the adolescent and parent questionnaires acted as a treatment pre-test for the prospective model and as a treatment post-test for the retrospective model. Given the duration of the pilot, it was not possible to do a post-test for the clients in the prospective model.

A "Mixed" model was also used, to provide an estimate of response rates that might be expected at the end of a prospective study. In this model, parents were involved in an ongoing study sponsored by one of the participating treatment agencies. Parents of members of the earlier Adolescent Project Client Descriptive Study were contacted by the agency and asked permission to release their names.

Those who agreed were contacted by the pilot interviewers and asked for permission to contact their children. Where they agreed, the adolescents were interviewed. Consequently, this "Mixed" model was prospective for the parents (since they were in the treatment agency's study) but it was retrospective for the adolescents, as they were interviewed by the project long after their treatment and without having been involved in any study earlier.

Table 1

Design of Pilot for an Outcome Study

MODEL	TARGET POPULATION FROM WHICH NAME RELEASES OBTAINED	QUESTION TIME RELATED TO ASSESSMENT-/TREATMENT
Prospective	Clients who entered treatment on or after 6/1/91	PRE-TEST: Just before/during early phase of treatment
TIME OF TREATMENT AND TIME AFTER TREATMENT: 12-20 months		
Retrospective	Clients Assessed in early 1990 & in Client Descriptive Study	POST-TEST: About 1-1.5 years after assessment

Agencies Determined First-Contact Persons

In both the prospective and retrospective models (as well as the "Mixed"), treatment agency staff were instructed on how to determine whether parent (the norm) or the adolescent (in special cases) should be approached first by the study. Following that determination, agency staff asked permission of that person, to release that person's name and phone number to the study. This name-release permission was obtained over the phone or in person.

Name Release and Confidentiality

In the spring of 1991, a proposal for the Pilot for an Outcome Study was developed and presented to the Human Research Review Board. The proposal

included the protocols, consent forms, and instruments, as well as the purpose and target population of participants, of the pilot outcome study. The Board approved this proposal on June 24, 1991.

The Adolescent Project and the Human Research Review Board both required only verbal permission for name release from the first-contact person (parent or adolescent). The project asked treatment agencies to give or send their list of released names to the Project on sheets signed by agency staff, so the responsibility of deciding on appropriate first contact rested with the agencies. Even so, two agencies made the decision to require a signature from those who agreed to name release.

Parent and Adolescent Interviews

Both of these instruments asked questions concerning the month just preceding the interview. This brief time period was decided partly because of the recommendation of agency staff, who stressed that what is a short time to an adult may be a very long time to an adolescent. As shown in Table 1, this means that in the prospective model questions were about the few weeks just preceding or at the same time as the beginning of treatment. In the case of the retrospective model, the questionnaires were asking about a recent time that was 1 to 1.5 years after the adolescent's assessment (not all clients in the Descriptive Study were in treatment, as the sample for that study was a sample of all assessed adolescents).

After name release lists were received from the agencies, appointments were made with first-contact persons. Meetings of interviewers with these persons were at places chosen by the contacted persons. They were generally at the homes of parents. For adolescents, the meeting place was frequently at a restaurant or, in prospective cases, the treatment agency. At these meetings, the Pilot for an Outcome Study was explained. In cases when the person contacted signed an informed consent, an interview was conducted. The one exception was that interviews were not conducted with parents of adolescents treated at one of the four retrospective model agencies, where these parents were participating in a follow-up telephone study.

Part of the consent procedure with the person first contacted was to ask permission to contact the other. If the parent was first, he or she was asked for consent to contact the adolescent, and vice versa. These procedures are outlined in the Flow Chart on p. 53 of the Appendix, which is followed by the instruction packet sent to agency staff.

Techniques Used to Obtain Accurate Responses

While this pilot did not make any attempt to verify reports made by adolescents, parents, and counselors, it did assume that each of these sources would share what they knew or believed to be true. To be able to assess differences in reporting between respondents, and compare these with some standard of "truth," one would have to do fairly rigorous examinations of clinical data for comparison purposes.

Respondent reliability and validity is a major issue in the area of chemical dependency studies. Verbal reports are the method most generally used to get information on substance abuse and on how it may be decreased or eliminated through treatment programs. Because of the problem of widespread denial in both chemically dependent persons and their family members, it is difficult to assure the congruence of reporting by various respondents.

There are numerous methods that may maximize the validity of answers: the closeness of any respondents' answers to the "truth." Babor, Stephens, and Marlatt (1987), discuss numerous ways of getting more validity from interviews. In this short pilot, several techniques mentioned by Babor as having demonstrated effectiveness in increasing validity were used. These included the following:

1) Establishing rapport with the respondent. Pilot interviewers were trained in two all-day workshops, one of which included practice interviews with adolescents who had just completed treatment.

2) Conducting all interviews in a clearly confidential context. This was, naturally, mandated by Human Research Review Board requirements. The pilot study made additional concerted efforts to develop Confidentiality Statements that were simply worded and clear.

3) Motivating the respondents. Adolescents were given gift certificates to acknowledge their contribution to the project, at the end of their interviews. Parents were recognized by being asked their opinions, and thanked for assisting.

4) Asking about recent rather than life-time activities. Both parents and adolescents were asked, in their interviews, only about behavior of the adolescent that occurred in the past month. Some parents commented that this was frustrating for them, as they wanted to report on a larger time span, but this technique is suggested in the literature as advisable for

persons with histories of chemical dependency, as being less confusing to them. (Counselors were asked about longer time spans, on the assumption that they would not be likely to be emotionally involved or to have impaired memories.)

5) Using clear instructions. Interviews were kept fairly brief (under one hour), and questions short, to allow respondents to easily follow the meaning of questions and to help them find the interview situation comfortable and non-threatening.

Gift Certificates

Adolescents who completed interviews were given a choice of gift certificates, redeemable for $10 worth of clothing, books, or records/cassettes. Stores sold these to the Adolescent Project at a discount which averaged 20%.

Counselor Interviews

After all adolescents from a treatment agency's list had been contacted and interviewed, the interviewer made an appointment to see a counselor who knew the adolescent. A short questionnaire (ten minutes) was used to interview the counselor.

School Records

Consent for school records examination was obtained from adolescent and parent pairs for 16 cases. Due to staffing and travel limitations (because it was expected to have to work in the schools to obtain school data and because the pilot was running out of time), only the eight adolescent cases in schools in western Washington had school records queried.

Two of the eight cases had given names of schools where they were not in attendance during the period for which information was sought. Both their previous and current schools were consequently contacted. Information was obtained by mail, somewhat to the surprise of the Adolescent Project staff, on seven of the participants in the pilot study. (It had been assumed it would be necessary to have an interviewer search student files on site, in each school.)

Table 2

Agencies in Pilot for an Outcome Study

REGION	AGENCY/ LOCATION	MODALITY/ MODEL*	DESCRIPTIVE STUDY CASES**
1	Daybreak *** of Spokane	Outpatient/ "Mixed"	15
	Daybreak *** of Spokane	Inpatient/ "Mixed"	49
2	ADDS, Ellensburg	Outpatient/ Prospective	4
	Parke Creek, Ellensburg	Inpatient/ Retrospective	27
3	Olympic Center, Bellingham	Inpatient/ Prospective	20
4	Central Youth & Family Services, Seattle	Outpatient/ Retrospective	22
5	405 Program, Tacoma	Outpatient/ Prospective	21
6	St.Peter Chem.Dependency Center, Olympia	Inpatient/ Prospective	24
	Thurston/Mason Comm. Mental Hlth, Olympia	Outpatient/ Retrospective	10
SIX REGIONS	8 Agencies	5 OP & 4 IP/ 3 Retrospective, 1 "Mixed" (IP&OP), 4 Prospective	192 cases were in Client Descriptive Study

* Models: Retrospective: Target population was assessed in early 1990 & in Descriptive Study. "Mixed" = parent-prospective and adolescent-retrospective model, where parent phone study by the agency was ongoing before the pilot, and adolescents were enrolled as retrospective (post-treatment with no previous contact) respondents. Prospective: Treatment began 6/91 or later.
**Descriptive Study Cases - are listed by agency involved in pilot. These cases had clients' files examined and counselors queried in late 1990 and spring 1991, (all were assessed in early 1990) as part of the Descriptive Study. Only the retrospective models had Descriptive Study Clients as their target population, but the estimated number of respondents (who would agree to participate) in the prospective model was based on the assumption that the number should be nearly half the number of the earlier study's cases.
***This agency has both Inpatient and Outpatient facilities.

AGENCY ENLISTMENT

Enlistment of agencies began with on-site visits in April. These visits, and discussions with the directors of treatment agencies, continued through the middle of July. Most agencies were visited twice. During the first visit, the agency director was informed of the study aims and asked to consider participation. The second was when the interviewer for that area was introduced to both the agency director and selected agency staff. In the second meeting, details of the procedures to be followed for obtaining names to be released to the project were discussed at length. A packet of information and directions was given to the agency staff, and the information was explained by the Adolescent Project staff.

Requests for name releases began in most participating agencies by the end of June. Eight agencies agreed to participate. Four used the prospective and four used retrospective models (three "pure" retrospective and one "Mixed" retrospective where the adolescents were retrospective). One of the agencies has inpatient and outpatient facilities. There were three other inpatient and four outpatient agencies. Each DASA region was represented, with Regions II and VI each having two agencies involved. Key factors in the choice of agencies were: 1) number of DASA-funded adolescent cases, 2) minimal scatter within the state, and 3) willingness to assist in the research task.

The number of cases included in the Adolescent Project's Client Descriptive Study was used as a proxy for estimating the current DASA caseload (see Table 2). One problem with this assumption was that one agency had changed ownership and some policies, and had only two DASA-funded adolescent beds in mid-1991.

Problems with Agency Enlistment

Three of the agencies who were asked to be in the pilot seemed interested initially, and they later declined. Their reasons were staff health, time available, and contract changes (one expected to serve few adolescents in the future). Those that participated were very supportive.

Agency De-Briefing

Data-gathering was completed on August 9, and staff from participating agencies met with research staff in an all-day agency de-briefing session on August 24, at

SeaTac. This made it feasible to share preliminary findings of the study with the treatment staff, to hear their recommendations for improving procedures, and to share some of the options being considered for conducting an outcome study in the future.

Summary

This section gives an overview of the design of the study. The study was a pilot for an outcome study of adolescents treated (with state funding) for chemical dependency in Washington State.

This pilot was undertaken to test two models (prospective and retrospective) and various procedures (for getting permission for name release, for obtaining informed consent, and for interviewing parents and adolescents), and to develop instruments and protocols for gaining data from parents, adolescents, counselors, and schools.

CHAPTER 2: FINDINGS ABOUT PROCEDURES

NAME RELEASE ISSUES

Name release was much more difficult to obtain than expected. It was hoped the eight agencies participating would be able to find 100 persons to agree to allow the agencies to release their names to the Adolescent Project for the pilot study. Only 39 persons agreed to name release, and 30 of those agreed to participate and were interviewed. Factors in this difficulty were a caseload dip for adolescents in the summer, and some agency/local caseload slumps for the prospective model. Most of the problem, however, related to several aspects of the retrospective and "mixed" models. These aspects included the time demands, on agencies, for searching for current phone numbers of former clients and the apparent impossibility of locating and reaching the majority of former clients.

Table 3

Number of Persons in Pilot for an Outcome Study

TIME FRAME	MODEL	ATTEMPT TO REACH	CONTACT	NAME RELEASE	INTER-VIEW
PRE-TX	Pro-spective	18	18	12	9
	NO PROSPECTIVE RESPONDENTS CONTACTED POST-TREATMENT				
POST-TX	"Mixed"	62	27	19	15
	Mixed model clients were only contacted Post-Treatment [but their parents were involved in a treatment agency study]				
	Retro-spective	59	18	8	6
	RETROSPECTIVE CLIENTS CONTACTED 1-1.5 YRS POST-ASSESSMENT				

Retrospective model: agencies tried to get permission for name release from parents of clients from Descriptive Study. "Mixed": agency where Descriptive Study sample's parents were in phone study (prospective); these were not interviewed in pilot.

Of the eight agencies, the three smallest (in DASA-funded adolescent caseload) were in Olympia and Ellensburg. Two agencies participated from each of these two areas. They were expected to produce, together, a number of names comparable to those obtained in the larger agencies. One outpatient agency, with a fairly small number of clients in the Client Descriptive Study's sample, was unable to obtain any name releases. This was an agency where the prospective model was used.

In three of the participating agencies, an entirely retrospective model was used. A total of 59 cases from the Client Descriptive Study came from these three. They attempted to obtain name release permission from parents (generally) of these persons. Just 18 (31%) were reached, and only 8 agreed to name release. These represent 44% of those reached, but under 14% of the target cases from the earlier descriptive study.

In one agency, a "mixed" model was used. There was a prospective parent phone study there, but the model used for the pilot was retrospective. For this reason, cases from this agency are reported in the tables here as "mixed". Parent interviews at that agency were not part of the protocol of the Pilot for an Outcome Study, though they were part of the standard procedures in both the retrospective agencies and in the prospective agencies. Even in this "mixed" model, with its history of ongoing parent contacts, the agency had difficulties reaching and getting name release permission from parents. Of 62 Client Descriptive cases from the "mixed" model, 27 (less than 44%) were found and contacted.

VARIOUS "SUCCESS RATES" IN THE TWO MODELS

Name release and interview "success rates" in the prospective model contrasted with contact rates of the retrospective models. Of the parents contacted in the "mixed" model, 19 agreed to name release (70% of those contacted, and 31% of the "target" group). This was the highest name release rate of the three situations in the pilot. The "Mixed" consent/interview rate was also the best of the three, with over 78% of those whose names were given to the project signing the consent. This is strong evidence in favor of the prospects for good returns with a future outcome study set up as a prospective study, since this model acted in some ways as an estimate of the return rates one might expect with a prospective study at the post-test (one year or more post-treatment) phase.

In the prospective agencies, 18 new clients were approached by agency staff, and 12 agreed to name release. (Obviously, no contact rate is calculated for the prospective model, since agencies naturally succeeded in reaching all their new/current clients whom they attempted.) Because 12 of the 18 agreed to name release, the "name-release success rate" in the prospective model was 67% (com-

pared with 44% in the retrospective model). Nine of the 12 persons contacted agreed to be in the study and were interviewed, so the prospective "interview success rate" was 75%.

Table 4

Name and Interview Success Rates in the Pilot for an Outcome Study

MODEL	CONTACT	CONSENT TO NAME RELEASE	NAME RELEASE RATE*	CONSENT TO INTER-VIEW	INTERVIEW SUCCESS RATE**
Prospective	18	12	67%	9	75%
TREATMENT & TIME (about 1.5 YEARS)					
"Mixed"	27	19	70%	15	79%
Retrospective	18	8	44%	6	75%

* Name release success rate is the percent of those contacted who agreed to name release.

** Interview success rate is the percent of those who agreed to name release who also signed the consent to participate. These persons were then interviewed, except in the "mixed" model, where only adolescents were interviewed.

DIFFERENCES IN CONTACT AND NAME-RELEASE RATES

The principal finding of the Pilot for an Outcome Study, about contact success in the two basic models (retrospective and prospective), is that the number of persons reached by the entirely retrospective agencies was 18 out of a possible 59 (31%), while the contact rate of the "mixed" model (where the agency had been in contact with most of the parents several times a year, since the adolescents' treatment began, was 27 out of a possible 62 (44%). Prospective model contacts were not calculated, because agencies were involved in frequent contact with their starting clients. This shows a considerable advantage for early contacts and for contacts intervening between treatment and post-treatment outcome interviews, in terms of access to clients.

Another striking difference between the retrospective and the prospective models of the pilot is that the name release success rate for the three retrospective agencies was 44% of the persons contacted, as compared with 67-70% in the other models (see Table 4).

It had been assumed, in planning the pilot study, that at least half the "target" population would be available for interviewing in each model. Less than one in five of the persons attempted to be reached was reached and eventually interviewed in the retrospective and "mixed" models combined (21/121--18%). This did not appear to be an acceptable "final success rate" for an outcome study, especially since there was no evidence that this minority was representative of the adolescents assessed, or of those treated.

CONTACT PROCEDURES

Of all the first-contact names released by the agencies, four adolescents were named as "special" owing to circumstances having to do with their families, and another three were listed as first contacts because they were over 18 years old. The agencies had been asked to class as "special" the adolescents whose parents did not know they were in treatment, or who were known to have special relationship problems, such as being physically or sexually abused by family members. These four, of the 39 names released to the project by the agencies (10%) were not parent-first contacts.

Consent Procedures

The consent procedures were apparently effective and appropriate. Seventy-seven percent of the persons called by interviewers consented to participate in the study. Although there was some repetition in the informed consent papers that were read to prospective participants, interviewers reported that the material was clear and useful in explaining the study. Few of the parents or adolescents contacted asked questions that could not be answered by simply repeating material in the consent form. Most respondents seemed pleased to be able to assist in the study.

Among the non-consenting nine pairs, there were five refusals and two runaways who could not be interviewed. In one case this was because the adolescent lives out of state, and in the other there were time limitations that made the consent procedures not feasible by the end of the project. There was also one parent who postponed an appointment because of a family problem, past the time when all pilot interviews had to be completed. One name was received too late. The pilot's final "interview success rate" with potential participants was consequently 77% (30 of the 39 names available to it).

When parents consented to participate, their adolescents were interviewed as well, and when adolescents consented--even "special" adolescents, they generally were willing to have their parents contacted. There was only one of the four "special" cases in the pilot where an adolescent did not want his parent(s) contacted.

The parents in the "Mixed" model wanted to talk. Consent meetings with them were fairly time-consuming, apparently because of their desire to discuss their adolescents. This was an interesting finding, in that the opposite had been expected. As noted, the decision not to interview the parents in the "Mixed" model came from assuming that because they were being queried by phone they would not want to answer more questions. That was not so for the 15 parents willing to have their children cont-
acted; they were apparently interested in discussing their children's situations.

This seems to have implications for any future outcome study. It would seem that parents should not be underestimated as information sources. They are generally willing to share what they perceive as happening in their adolescents' lives. Furthermore, their lives are often more stable than that of their children, in terms of having steady and secure homes and jobs. This makes them much easier to contact.

It might be of interest, in an outcome study, to examine the relationship between parent and adolescent reports of factual and judgmental matters such as use of alcohol and adolescents' cooperation in their homes, before and after treatment. (If treatment decreases denial, and increases honesty, one would expect that there would be increased agreement between parents and adolescents after treatment.)

Three of the four interviewers who worked in the pilot noted fairly strong differences between the manner of potential respondents on the telephone and in person. Phone contacts for making appointments were, of course, first contacts from the interviewers. Still, interviewers were impressed with the greater openness--even before they had gone through the informed consent procedures--of virtually all respondents when they were meeting them in person.

TIME DEMANDS IN THE TWO MODELS

It has been observed that the proportion of persons contacted in the "target" population (successful contacts out of persons attempted to reach) differed between the "entirely" retrospective model and the "Mixed" model, with the former having a contact rate of 31% and the latter one of 44%. One cannot, of course compare a contact rate for the prospective model, since agencies were in constant contact with their current clients.

The name-release rate, however, compared interestingly between the prospective and retrospective models. In the retrospective model, that proportion (persons agreeing to name release out of all persons contacted by the agencies) was 44%. In the "Mixed" model, the name-release rate was like that of the pros tive model (both were close to 70%). This seems to show the advantage of a prospective study, even in post-testing, since the "Mixed" model was (on account of the parents' ongoing involvement in the agency study) comparable to a prospective post-test.

But response rates alone did not constitute the entire "question" about the models: almost as important was the practical issue of time. Could the retrospective study (certainly a more economical approach to an outcome study) compare in terms of the time demands on various participants? The time issue was examined primarily from the two aspects of interviewer and agency time requirements.

Interviewer Times: Travel, Phone, and Interviews

Travel and interview time requirements were large, and beyond expectations. It was planned to use just agencies in Spokane, Kittitas, King, Pierce, and Thurston Counties, to minimize travel. Neither limiting the pilot to those counties nor minimizing travel proved possible. An inpatient center in Bellingham was added in July, to make the fourth prospective agency; and it was not possible to keep travel miles few, because residences were not geographically concentrated.

Though clients treated on an outpatient basis by agencies in the prospective model tended to live in the county where they received treatment, clients treated earlier (retrospective), and most clients treated in inpatient facilities, lived all over the state, and beyond. One interview was done with an adolescent in Idaho, and another was not done because the adolescent is now living in Colorado. Miles traveled by interviewers were far more numerous than expected.

Time was needed for other things as well as travel. Interviewers found that it often took many calls and many hours to reach persons who had agreed to name release. Parents and adolescents might be away on vacations, working odd hours, or simply busy. It was hard to know the best time to reach parents by phone. Adolescents were especially hard to reach, as the pilot was carried out in summer. Finally, there were hours when interviewers waited for persons who had made appointments with them. All these people were eventually interviewed, but sometimes they were late and sometimes they forgot appointments.

Even though parents in the "Mixed" model were not interviewed, they took much time to sign the consent and agree to have their adolescents contacted. Apparently this was because they wanted to share concerns about their children with the

interviewer. In all, prospective cases averaged over six and a half hours of interviewer time, while retrospective cases averaged over eight and a half hours, though over two-thirds (the "Mixed" cases) had no parent interview.

Table 5

Interviewer Time by Procedure in Pilot for an Outcome Study

MODEL *	PHONE HOURS	TRAVEL HOURS	CONSENT & INTERVIEW HOURS **	TOTAL # HOURS	TOTAL # CASES	HOURS/ CASE
Prospective (PRE-treatment)	2.2	44.1	14.7	61.0	9	6.8
"Mixed"	5.9	72.0	18.9	96.8	15	6.5
Retrospective	3.7	57.8	24.7	86.2	6	14.4
All Retrospective (POST-treatment)	9.6	129.8	43.6	183.0	21	8.7
Total Interviewer Hours in Pilot	15.5	201.8	62.5	279.8	36	7.8

* Model - Prospective: current agency clients' parents were contacted by agency and asked if for permission for name release. "Mixed": parents of clients from Descriptive Study who were in an ongoing study in one agency, where the agency phoned them regularly; these were contacted by that agency. Retrospective: parents of clients from Client Descriptive Study were contacted by treatment agencies, more than a year after assessment, to ask permission for name release.
**Cases = consenting first-contact persons; all but one case involved two persons. In 30 cases, there were 30 adolescent interviews, 30 counselor interviews, and 14 parent interviews.

File Checking and Phoning Times, and Other Agency Tasks

The cost in agency time was excessive in the retrospective models. Fundamentally, agency staff found all matters relating to former clients took more time than those about current clients. This was especially so when it came to attempts to reach former clients or their parents by telephone to ask for permission to release names.

In Table 6, times are shown by model, by names released, and by cases interviewed. While average agency time per case was less than one hour in the prospective model, it was two and a half hours to almost three hours in the two retrospective models.

These agency times are more approximate than the times reported by pilot interviewers. The reason for this is that the interviewers were trained, from the beginning of the pilot, to report time spent on various tasks each day. The time and task sheets they used to record their activities were submitted weekly, and the reporting form was revised once during the pilot to make it easier to complete. Times reported by the agencies, on the other hand, were reported only once, by telephone.

Table 6

Agency Time by Procedure in Pilot for an Outcome Study

MODEL	AGENCY HOURS NEEDED FOR PILOT PROCEDURES				PERSONS CONTACTED		HOURS /NAME RE-LEASED	HOURS/ CASE INTER-VIEWED
	FILE WORK *	ASKING NAME RE-LEASE	COUN-SELOR INTER-VIEWS	TOTAL HOURS	NAMES RE-LEASED	CASES** INTER-VIEWED		
Prospective (PRE-treat-ment)	2.5	2.8	2.8	8.1	12	9	0.7	0.9
"Mixed"	20.0	20.0	4.1	44.1	19	15	2.3	2.9
Retrospective	6.3	7.8	1.5	15.6	8	6	2.0	2.6
All Retrospec-tive (POST-treatment)	26.3	27.8	5.6	59.7	27	21	2.2	2.8
Total Agency Hours in Pilot	46.	47.8	9.7	103.8	46	36	2.3	2.9

* File work included determining client ages, parent phone numbers, and (sometimes) "Special" status of adolescents under 18.
**A case consisted of a "First-Contact" person (parent or "Special" adolescent) who consented to participate in the pilot, and any other respondent(s) from that family.

Agency staff were not asked to record times spent on various tasks as the pilot progressed, because it was felt this might seem intrusive to them. Instead, a phone call was made to each agency, about a week after the end of the pilot's data-gathering phase. Some agency staff members responded quickly and with assurance to questions on how long various tasks took them, but others seemed less assured.

GIFT CERTIFICATES

It was difficult to estimate how adolescents would choose gift certificates. Considerable checking had been done to find stores that were willing to give the project a discount on certificates and that had branches in a number of communities around the state. Discounts were sought not so much to save funds as to build goodwill. (In a full outcome study, as many as 900 gift certificates might be needed, and considerable savings might be realized, in that case, as a result of discounts.)

Many community businesses are concerned about the welfare of youth, and the four stores involved seemed pleased to assist in any effort that might result in improving young peoples' treatment and assisting with their recovery.

Choices of gift certificates were more dispersed than expected (see Choice of Certificates, Appendix Table 4, on p. 74). Eight participants chose a certificate redeemable for clothing, 16 for music, and five for books. One respondent refused the certificate.

Summary

When agencies asked the parents of their clients or former clients (or the adolescents themselves in a few special cases) for permission to release their names to the study, 39 persons agreed. Thirty consented to participate.

Major differences between models were in the proportions of contacted persons who agreed to name release and in the time requirements. Fewer of those contacted agreed to name release in the retrospective model than in the prospective. Both interviewers and agencies reported that the retrospective model took more time per case. The time needs ranged from under an hour per case for the agency and less than seven per case for the interviewers in the prospective model to over two and a half hours per case per interviewer and over 14 per case for the agency in the retrospective model.

Choices of gift certificates were more varied than expected: over half chose a certificate redeemable for music, while about three-fifths chose clothing and two-fifths books.

CHAPTER 3: FINDINGS ABOUT INSTRUMENTS

QUESTIONNAIRES NOT TESTED FOR RELIABILITY/VALIDITY

It was necessary to prepare pilot plans and write the three questionnaires for the Human Research Review Board application, in the spring of 1991, in a brief period of time. It was not possible, in that time, to obtain and use sections of standard instruments for the various question areas that had been determined to be central to an outcome study. This was seen as a problem by both the Adolescent Project staff and the Review Board, as can be seen in correspondence about the issue which occurred between the two groups.

Two steps in the direction of using parts of standard tools were taken, however: 1) the Urban Institute's two volumes "Monitoring the Outcomes of Social Services" (Millar, Hatry, and Koss, 1977) were studied and some of their questions used as models, and 2) a number of the questions in the Adolescent Project's earlier Client Descriptive Study questionnaire were adapted for use in the pilot's personal interviews. Nonetheless, it is advisable, before any outcome study be initiated, that the data-gathering tools of the pilot be revised and compared with numerous standard instruments that have been tested for reliability and validity.

PARENT INTERVIEWS

To evaluate questions used in the pilot study's parent questionnaire, four sources were considered: 1) interviewer comments at project staff meetings during the pilot study, 2) respondent answers to the question "Do you have any further comments?" (Q.59), 3) interviewer answers to the question "Any further comments by the interviewer" (Q.64), and 4) project staff observations of the data after completion of the pilot.

Questions Suggested to be Added

The aim of the parent questionnaire was to center on the issue of the adolescent's recent functioning in the family or household where he or she was most recently living. Most of the questions (33 out of 58, 57%) dealt with such functioning. Secondary issues to be asked about were school or work, treatment experience, and recent use of drugs and/or alcohol. The proportions of these three types of

questions in the pilot parent instrument were: school/work, 16%; treatment, .5%; and recent use of substances, .5%. Certainly, it would be appropriate to add further questions on the topics of the adolescent's treatment and recent use of drugs and/or alcohol.

In addition to treatment and use details, other areas where it was suggested that more questions should be included were the legal and substance use problems of both adolescents and family members, and social support needs of the adolescent to assist in his or her recovery.

Parent Questionnaire Brief and Apparently Satisfactory

At the beginning of the pilot, interviewers made some critical observations concerning all three of the questionnaires; problems and concerns with all the instruments were discussed at weekly pilot staff meetings during the study. The parent questionnaire elicited few comments, however. It proved fairly easy to administer, taking on the average only half an hour. Parents seemed happy to answer the questions posed of them, according to interviewers' reports.

As noted, respondent comments were also considered in evaluating areas where the parent questionnaire might be profitably modified. When parents were asked (at the end of the interview) if they had things they'd like to add, the bulk (well over half) of their comments dealt with the adolescent's treatment. This seems to add force to the observation by project staff that the parent questionnaire should add questions about treatment modality, the qualitative experience of treatment for the adolescent and family, and details of continuing care.

Suggestion: Add a Second Time Frame

One area where some interviewers had concerns about the appropriateness of questions was in the time unit defined as "recent": the past month. Some interviewers and a few parents suggested that a month is a very short time. (As noted above, Babor considers use of short time frames in interviews of or about the chemically dependent to be one of the most important ways one can use to increase valid responses.) This concern about recent time, of course, applied to both the parent and the adolescent interview questions. Perhaps some questions dealing with the past three months should be added to both; this is, at least, one option to consider.

Other Suggestions

In addition to the above, the following suggestions developed at the end of the data-gathering phase of the pilot, after all responses were examined:

(1) Add current or just-completed treatment (inpatient) as a new option for recent household situation.

(2) Group the responses for number of overnights without permission (q.24), as:

1-2	7-8
3-4	9-10
5-6	11+

(3) In all responses, list choices in ascending order in one or two columns (as proposed immediately above). Interviewers felt such grouped responses would be simpler to ask and code.

(4) Ask about ethnic group (Hispanic vs. Non-Hispanic) before asking about race (this should avoid confusing the two): i.e., reverse the order of questions 54 and 55.

In sum, then, it is proposed that the parent questionnaires would profit from the addition of further questions on adolescent use of substances, the careful examination of standard instruments (with a view to using parts of them), the possible addition of a second (three-month?) time frame, and a few minor changes in wordings and orders.

ADOLESCENT INTERVIEWS

The major emphasis of the adolescent interview was to examine the use of substances, if any. Secondary focus was on family functioning and how adolescents were doing in school or at work.

Questions Suggested to be Added

As the parent questionnaire may benefit from more questions about adolescent substance use, so the adolescent questionnaire could benefit from the addition of more questions about getting along at home and school or work. Both questionnaires might benefit from a few judicious questions about the history of the adolescent's chemical dependency problems. (Such questions would, obviously,

have to go back in time a considerable ways, for some clients. It would not seem a good idea to have more than two or three such questions, given the concerns expressed in the literature about the decrease in validity with the increase in time span of questions.)

Most of the comments above, concerning the Parent questionnaire, apply also to the Adolescent questionnaire. Examination of tested and standard documents, with a view to including at least parts of them to be able to assure reliable and valid responses, is the major need observed.

Adolescent Questionnaire Appropriate in Length

One of the important considerations, in revising the Adolescent questionnaire, is not to make it longer. Interviewers reported that the length was workable, but that one would not want to have the questionnaire much longer. If it is seen as important to add parts of standard instruments, and to increase the number of questions dealing with family and school functioning, then it will probably also be necessary to omit some of the questions on the current questionnaire.

Appropriateness of Questions

A number of questions in the adolescent instrument asked for a Likert scale response (as q.20, "How serious have your problems been recently, with your friends?" on a scale of 0 to 4, where 0 = Not at all, and 4 = Very serious). A few of these questions were too broad for single answers, especially of this type. Question 20, for instance, was difficult for some respondents. They often have a number of friends, and, while problems with some may be great, they may not have any problems with others.

Some questions asked of only retrospective clients were in several places on the instrument. It would have made a smoother interview had all these been grouped together. Also, retrospective clients sometimes had difficulty recalling details of their treatment, which was in some cases either brief or ended more than a year ago. (This doubtless relates to the brief-time-is-best issue discussed earlier (Babor, 1987).

One question should clearly have been marked a "skip" for adolescents who reported no use of drugs or alcohol: question 82 asks whether respondents would like to be referred to a treatment center. Interviewers had felt, from the early development phases of the instrument, that this was an awkward question. It had been inserted at the suggestion of staff concerned that we should offer help if

clients were clearly having difficulties. At the agency de-briefing day, noted earlier in discussing procedures, this question was mentioned by agency staff as not needed, since clients are given much information on how to get help when they need and want it.

It would be helpful to broaden drug and alcohol use questions by asking about early and later substance use in addition to most-recent use. One positive outcome that sometimes occurs after treatment of adolescents is more cautious and selective use of substances (Ito and Donovan, 1986; Wells, Hawkins, and Catalano, 1988; and Catalano et al., 1988). This is admittedly not the same kind or degree of "success" as total abstinence. Even so, it can be a step taken in the direction of recovery and is, consequently, worth documenting.

Suggestions for Revisions

As with the parent questionnaire, reordering and renumbering questions and responses in the adolescent instrument are obvious first steps towards making the interview smoother, for both the respondent and the interviewer. Question 82 should either follow questions 42-50 and be marked a "skip" for those not using or it should be omitted altogether. Also, as with the parent instrument, it is advisable to include at least parts of some standardized instruments to allow comparison with other groups in other places, and to be able to assure reliability and validity of a number of questions.

These two suggestions, to renumber and rearrange pilot questions and to add portions of standardized tests, are the major ones clearly indicated by the pilot. If the instruments developed for the pilot were used as the basis for those in a full outcome study, and if the decision were made to continue (apart from the use of select post-treatment questions for those in follow-up) the use of one instrument for persons at various times after assessment, then it would seem highly advisable to add questions about first and later (pre-treatment) patterns of use of drugs and/or alcohol, at least in the first-used instrument.

Other Suggestions

The Adolescent questionnaire contained more problems of wording and word order. Some wording changes are necessary to increase understanding. After the completion of the pilot study and the compiling of the data, some additions and a few changes were made to the coding scheme on the basis of the responses received.

In brief, these changes, and the wording revisions noted as helpful, were the following:

(1) Add current or just-completed treatment (inpatient) as a new option for recent household situation.

(2) In questions 12, 14, and 16, replace the option "yes" as a response with "mostly"; it seems more appropriate, as the questions ask about frequency.

(3) In all responses, list choices in ascending order in one or two columns (as proposed immediately above). Interviewers felt such responses would be simpler to ask and code.

(4) In Q.61 (times met with sponsor), add another option:

5 Did not talk with sponsor

(5) Add a second services option after the question "Have you or your parents received any social services such as welfare, medical coupons, educational or vocational services, this past month?" (Q.89), and add "Food Stamps/WIC" as a new service option (this could be response option #6).

Note that many of these suggestions are similar or identical to suggestions for small changes in the Parent Questionnaire. Though the question numbers are different in that instrument, many of these are modifications that could help both instruments.

RESPONDENT COMPARISONS

Comparisons between parent and adolescent questionnaire responses were made for several questions, though there were only 14 pairable responses; for those of the "mixed" adolescent interviews where the agency's telephone interview with the parents had been completed recently, a less exact comparison could be made, between the pilot adolescent interview and the agency's telephone parent interview. This comparison could be done for only 12 cases, since others had dropped out of the agency study or had been interviewed by the agency more than three months in the past. The two types of comparisons (pilot parent vs. pilot adolescent questionnaire and pilot adolescent vs. recent phone interview by the agency) are discussed below, and agreements (defined as three out of four interviewers having judged the responses to be "very similar" are shown in Table 7.

Two Types of Comparisons

The comparisons were either of adolescent and parent pilot study questionnaire items or they were of adolescent pilot questionnaire items with the "Mixed" model's telephone interview of parents. The numbers of questions that were compared differed in these two situations.

There were nine prospective and five retrospective cases in the 14 where an adolescent and a parent pilot questionnaire could be compared. Responses to 16 questions common to all of these adolescent and parent questionnaires were compared, individually, by each of the four pilot interviewers.

Four other questions could be compared only for the five "purely" retrospective cases. This was because only retrospective model clients were asked questions about previous treatment. Thus, for these five cases, 20 questions were compared.

There were 12 cases where adolescent questionnaires were completed by former clients whose parents were in the "Mixed" model, and with whose parents telephone interviews had recently been completed by the agency's staff. Six questions from that phone interview could be matched with questions in the adolescent questionnaire.

The two comparison tables in the Appendix, Tables 2 and 3 on pp. 72 and 73, compare responses on those questions that could be compared where there was 75% or better agreement among the four reviewers. Clearly, some of these questions were more easily comparable than others.

Table 7 summarizes the responses the four reviewers judged to be "very similar." These are shown as percents of all possible responses (cases times questions), by category of question. In all three models and four of the five groups of questions, about half the adolescents and parents had "very similar" responses. One category of response, the use of drugs and/or alcohol, had a larger rate, with 56% of the prospective, 60% of the retrospective, and 79% of the "mixed" having a high level of agreement.

Another interesting point about the comparisons in Table 7 is that the agreement level was somewhat higher in the retrospective cases, compared with the prospective cases. It might be hypothesized, as noted earlier, that parent-adolescent agreement should be greater in the retrospective model (i.e., that there would be more agreement a year after assessment).

Table 7

Proportion of Very Similar Adolescent and Parent Responses in Compared Interviews* with Reviewer Agreement in Pilot for an Outcome Study

ISSUES	PROSPECTIVE			RETROSPECTIVE			"MIXED"			TOTAL		
	Very Similar	Total	%	Very Similar	Total	%	Very Similar	Total	%	Very Similar	Total	%
Family	33	81	41	22	45	49	13	24	54	68	150	45
Treatment	n.a.	n.a.	na	10	20	50	n.a.	n.a.	na	10	20	50
Drug/Alcohol	10	18	56	6	10	60	19	24	79	35	52	67
School/Work	19	45	42	8	25	32	12	24	50	39	94	41
Total	62	144	43	46	100	46	44	72	61	152	316	48

*The responses compared here are the responses of the parent and the adolescent Pilot for an Outcome Study questionnaires, except in the "mixed" model. In that model, the adolescent questionnaire of the pilot was compared with the agency study's recent telephone interview of the parents. Note, also, that the questions about a year earlier treatment, from the questionnaires could not be compared for the prospective model, since in that case those were "skip" questions.
Very Similar: answer judged by 3 of 4 reviewers to be "very similar."
Total Possible: number possible in agreement (model cases x compared questions).
The two source tables for this summary table are in the Appendix, on pp. 72 and 73.

As with all data from the pilot, one must exercise caution in making assumptions, as the numbers are small here, and the cases not the same, but a large outcome study could benefit from examining this area.

COUNSELOR INTERVIEWS

Counselor-derived information dealt with four subject areas: treatment; adolescent motivation and change; family situations; and post-treatment supports, including 12-step program participation. The checklist was completed by interviewers in discussion with counselors in the agencies who knew the adolescent pilot participants. This instrument included only ten question areas. Thirty such interviews were completed.

Appropriateness of Questions

Most of the questions in the Counselor Checklist were asked because personnel in one or more of the eight participating agencies had suggested such questions be asked. Another major concern addressed by this instrument was an awareness that, as noted in Brownell et al. (1986), events in a young person's life may play as great a part in recovery as treatment itself. Even so, it seems dubious whether agency staff can know answers to some of the post-treatment questions about family status.

Suggestions for Revisions

If a prospective outcome study were to be done, it would seem logical and useful to ask these questions concerning after-treatment life and family status, of their adolescent children and/or of the parents, in between-interview brief phone conversations. The counselor interview could then focus on the time and details counselors know best--the time immediately preceding and concurrent with the adolescent's treatment.

Comparison of counselor responses with those of adolescents and/or parents was not done by this study. It would seem advisable to plan such comparison as part of any outcome study. The literature includes numerous studies on the comparison of data about substance abusers, depending on informants (Babor et al., 1986). If parents and adolescents do not agree much more than half the time, is it possible that counselors and parents agree more? This would seem an important issue, and one sufficiently intriguing to make it advisable to include the addition of at least a few items duplicating those in the parent and adolescent interviews, in any revision of the counselor instrument.

SCHOOL RECORDS SEARCHES

Sixteen of the 30 adolescents in the study had been in school within the past year. Letters were written to the schools of half of these, those living in western Washington. This was done to pre-test school record search procedures but keep travel costs minimal. (It was expected that data would have to be gathered by an interviewer on site from student school files.)

Confidentiality was Protected

In the contact letter, no mention was made of treatment, in order to protect the anonymity of the adolescents. School personnel were told in the letter only that

the adolescent and parent had given permission to a research project (the Adolescent Project) to ask the school for information. Copies of the consent forms signed by the parent and adolescent were enclosed in the letter to the school principal.

Schools Provided Data by Mail

All the contacted schools agreed to respond by mail. This was a surprise; if it had been known earlier that this could be done, all 16 schools would have been sent letters. The letters from the schools, with the data they were able to send, were not received until almost two weeks after the end of the pilot's data-gathering phase, simply too late to extend our search for data.

Alternative Schools Kept Different Information

Four of the schools that responded were alternative schools. They notified the project staff that they do not keep records in the same way as other public schools. Grades, attendance, and conduct reports are all reported differently in alternative schools, the project was informed.

If an outcome study should be undertaken at some future time, it would seem advisable to hold meetings with administrators from some standard middle and high schools and from several alternative schools, to ask for ideas and suggestions from them about what information to gather. They could then also be asked how to put together the data-collection forms, in order to obtain the most, and most usable, information, with the least trouble to the schools.

Summary

There were 30 adolescent interviews completed during the pilot study, along with 14 parent interviews, and 30 counselor questionnaires. Eight schools were queried about the records of adolescents, and seven sent information by mail.

Major recommendations for revision of the questionnaires are for the addition of sections of standard (tested for reliability and validity) instruments to the parent and adolescent questionnaire, and some re-arrangement and minor editing changes to them. Some additional use questions in the parent instrument, functioning questions in the adolescent instrument, and treatment questions in the counselor checklist are suggested.

School data gathering can probably be done in an outcome study by mail rather than by on-site file searches. A major problem about school data which was found by the pilot, however, is that alternative schools do not keep the same sorts of records as other schools. This will require some investigation, to find what are appropriate questions for alternative schools.

CHAPTER 4: FREQUENCIES OF RESPONSES

As has been noted above, the purpose of the pilot was to determine whether a prospective study would have significant advantages over a retrospective study, for examining outcomes of state-funded treatment of adolescents for chemical dependencies. Developing procedures and instruments for gathering data from parents, adolescents, counselors, and schools was the secondary aim of this pilot.

RESPONDENTS DO NOT REPRESENT POPULATIONS

Because of the opportunistic way the study participants were obtained, there was no idea of obtaining outcome data from this brief pilot. Responses given, in the questionnaires and other data-gathering tools of the pilot, cannot give us estimates for the population of adolescents assessed in early 1990 or who started treatment in the summer of 1991. It is critical to keep in mind, while examining these responses, that they are giving anecdotal evidence only, and that for a very few persons.

In spite of these limitations, and because their responses can give us an idea about some of the feelings and opinions of those 30 adolescents, 14 parents, and 30 treatment agency counselors who were interviewed, such data as was obtained will be briefly discussed in this chapter. (The respondents' answers may also give us some hints about ways in which the instruments should be revised, as noted in the previous chapter.)

For each of the data sources, some issues will be looked at in terms of all respondents. One reason for this is that there were very few respondents, and another is that the responses may tell us something about the appropriateness of wordings in the pilot questionnaires.

Some issues will be separated between models, so that one can see how respondents in the prospective model answered and how those in the retrospective model answered. Finally, for a few issues, responses will be reported by model and by whether the adolescent completed or did not complete his or her prescribed chemical dependency treatment.

PARENT RESPONSES

Frequencies of Responses

Though the project had been willing to interview parents as pairs if they wished to respond that way, the 14 interviews conducted with parents were all with single individuals. Five were with men and nine were with women. Two were members of minority groups (one a Black and one an Hispanic). Five of the 14 parents stated their adolescents were living with the mother, and four stated with the father. Only one adolescent was living with both natural parents. One was in a foster home, and one was living with her "significant other."

The major aim of the parent interview had been to measure the functioning of the adolescent within the home. Noteworthy responses, in respect to family function issues, were those about helpfulness and following rules. Eight had positive ("good" or "fair") responses about helpfulness, and five said their adolescents did "moderately well" about following household rules. Four reported that their children "openly rebel" against these rules. Seven of the parents said their children are either actively or occasionally involved in normal household activities, but 12 reported they were actively or occasionally involved in special family activities.

There was an interesting contrast between what parents said about adolescents' social skills and about their use of leisure time. In judging their children's social skills, ten of the parents interviewed commented positively, saying these were either "excellent" or "good," while the rest judged them to be "fair" or "poor." About their teens' use of leisure, however, parents were less positive: three said it was "constructive" or "good," five described it as "fair", three as "generally poor," and one as "awful."

Another area of particular interest in the parent interview was that of questions dealing with adolescent substance abuse. To the question of whether they believe their children used any drugs or alcohol, in the past month, four said "both," eight said "no," and two said they did not know. Of the frequency of use of these substances in the past month, two estimated they used them between "1 or 2 times" and "several times." Two stated they had observed evidence of drinking or drugging by their children, such as bottles or drug paraphernalia.

Outcome Measures

Because the pilot, conducted in a period of less than seven weeks, was unable to compare "before" and "after" treatment responses of individual parents, it was not possible to arrive at any true "outcome" measures. The structure of the pilot study was such that for respondents of the prospective model answers were obtained about their situations very early in treatment. For retrospective cases, answers were obtained about a year and a half after the adolescents were assessed. Thus, there were very few questions in any of the three questionnaires that dealt with comparisons of pre- and post-treatment situations, feelings, or skills.

In the parent questionnaire, Question 36 asks "If (the adolescent) has been in treatment within the past year, how effective do you feel that treatment has been?" Answers to this question by the five parents in the retrospective model were: extremely effective, 1; quite effective, 2; moderately effective, 0; slightly effective, 1; not effective, 1; detrimental, 0; and unknown, 0.

Only 2 of the these five parents said they believed their children had used any drugs or alcohol in the past month, and only one said that he or she had found any actual evidence of drug or alcohol consumption (Q.43). Thus, among the five parent respondents of the retrospective model, most felt their children were continuing in abstinence. These were really the only questions that could be seen as comments on outcomes, since the pre- and post-measures were not done on the same clients in the pilot.

RESPONSES BY TREATMENT COMPLETION

Whether or not adolescents had completed or nearly completed their treatment was defined by the responses of their counselors to this question. If counselors stated adolescents had completed one or more planned programs or were near completion of a program, those adolescents were classed as having completed. There were seven of the nine prospective cases where this was so, and 15 of the 21 retrospective cases. Not all of those cases which were not classed as "completed" were clients who had left treatment; one of the retrospective non-complete cases was assessed at the treatment center but not treated there. (We do not know if or where this person may have actually been treated.)

Recent Use Reported Low by Completers

Appendix Table 5, pp. 75-76, "Responses by Whether Adolescents Completed Treatment" lists responses by completion to a variety of questions in the parent,

adolescent, and counselor interviews. Since the numbers of responses are so small in this pilot, these responses may not be indicative of anything but chance. Even so, it can be seen that in none of the four situations is use of drugs and/or alcohol reported by more than 50% of the respondents. For those who have completed treatment, between 60 and 71% stated they were not currently or recently using either drugs or alcohol.

Completers Reported Feeling Supported

Support is a key issue in substance abuse treatment programs, especially in those that treat adolescents. Learning how to accept, use, and maintain support from family and friends is among the skills young people are aided in learning during their treatment. (This is not to be confused with "enabling," where adolescents or other substance abusers "use" people who love them to keep them supplied with money or drugs, and to help them maintain their addictions while staying in denial about them.)

Because support is so important, it seems interesting that 6 of the 7 prospective completers and 14 of the 15 retrospective completers reported fair or better relationships with household members. When adolescents were asked whether the people most important to them (generally close family members and friends) support their staying off alcohol or drugs, most answered yes. Seven out of seven who were prospective completers, both of the prospective non-completers, 14 of 15 retrospective completers, and five of six retrospective non-completers reported one or more most important persons were supportive.

Limited Number of Respondents

Because of small numbers, results of comparisons are not indicative of population situations. Nonetheless, Appendix Table 5 (on pp. 75-76) shows that an outcome study using the instruments developed by the pilot might obtain some interesting data if an adequate sample of parents, adolescents, and counselors were interviewed.

ADOLESCENT RESPONSES

Frequencies of Responses

Of the 30 adolescents interviewed, four reported living with both natural parents, 11 with their mothers and seven with their fathers. Four said there were step

-parents in the household, and 16 reported living with brothers or sisters. Two were in group homes, one in a foster home, and two lived with a "significant other."

The most critical questions in the adolescent questionnaire were about current use of drugs and/or alcohol. Seven adolescent respondents reported that they used only alcohol in the past month, and five said they used both alcohol and other drugs. Twelve of the 30 said they were involved in substance use within the past month. With respect to frequency, amounts, and types of alcohol or drugs, 11 adolescents reported using alcohol once or more in recent weeks. Eight said they drank anywhere from twice to more than six times in the past month, and only three said they drank less than three drinks at a time. Five said they generally had six or more drinks when they drank. Among the types of alcoholic beverages used, beer was named most frequently, with eight adolescents reporting its use.

Fewer respondents (four) reported using drugs other than alcohol in the past month. Two of these said they used drugs three to five times, and two said six or more times. All four said the only substance they used was marijuana. Six respondents altogether said they had problems with drugs or alcohol in the past month.

Fourteen had attended 12-step group meetings. Ten had attended twice or more often in the past month. Twelve said they attended Alcoholics Anonymous meetings, nine said Narcotics Anonymous, and four said they had been to Cocaine Anonymous meetings. These are not exclusive--it's highly probable that some went to two or more types of meetings. Seven adolescents reported having a sponsor in a 12-step program, and three had spoken with their sponsor in the past month outside of a meeting.

Reports of family involvement with drugs and alcohol contrasted with the adolescents' lack of participation in certain other 12-step groups. Two-thirds of the respondents (20) reported that they had family members who used drugs or alcohol, and 14 that they have household members whose use of drugs or alcohol causes problems for themselves or others. But none reported having attended any Alateen, Al-anon, or Children of Alcoholics meetings in the past month. Of course, we cannot tell from the small number and the few questions on these issues if there were such groups available and known to these adolescents.

School, work, and legal involvement were also examined in the questionnaire. Nineteen respondents said they are in school (including one in college), and 16 said they enjoy it, at least sometimes. Eleven said they are working, part time or full time, and ten said they have problems with school or work. Ten adolescents said they had some involvement with the legal system in the past month. Ten said they used violence or threats against someone in recent weeks.

As with the parent responses, because these are only a few respondents of the many adolescents treated last year and this summer, these responses represent simply the opinions of these adolescents. We can make absolutely no assumptions about other treated adolescents on the basis of these few persons' answers.

Outcome Measures

Pre-treatment drug/alcohol use histories and family functioning were obtained only for prospective cases in this pilot, because all questions on the instruments dealt with the past month only (except the questions asked only of retrospective clients and which dealt with earlier treatment). It is not possible, consequently, to compare pre-treatment with post-treatment status of any adolescents in this study. A few questions, however, had answers that might point toward outcomes: questions 42-50 on substance use, and 57-61 on using 12-step programs.

Of the 21 retrospective model adolescents, 15 said they completed their treatment. Fourteen said they feel they have "a lot more control" over their lives than before treatment. Fifteen said they had "a lot more control" over their lives now than in the month after their treatment ended. Seven of the retrospective clients said they attended a 12-step meeting in the past month. Ten of the 21 rated the treatment they had received as good or excellent (eight said the same of their aftercare), and six said treatment had helped them by giving them skills they could use to maintain recovery. Twelve said they had not used any drugs or alcohol in the past month, i.e., they report themselves to be "clean and sober," an optimal outcome.

COUNSELOR RESPONSES

Frequencies of Responses

Treatment questions asked of counselors concerned completion, modality, and aftercare. Including those "near complete," 22 adolescents were reported to have finished one or more prescribed treatment. Just two were said to have quit treatment, and another two to have been told to leave. One person was said to have left for a neutral (undetermined) reason, and for another the answer was missing. Two were only assessed, and not treated, and may have been treated elsewhere.

The modalities in which adolescents were treated were inpatient (20; 19 in regular and one in staff secure inpatient care) and outpatient (nine; eight in regular and one in intensive outpatient care). Another one was treated in a combination of

modalities. The follow-up or other post-treatments reported were: left to go into more intensive treatment (three); follow-up, with counseling once or more per week (16), with less than once a week (four), less than once a month (three); and no or unknown follow-up (five).

Outcome Measures

Motivation in treatment was another interesting area of the checklist. Though only 14 adolescents were seen as at least somewhat interested when they entered treatment, in 23 cases at least some positive change was seen as an outcome of treatment. Twenty-three counselors said the families were at least somewhat concerned when their children entered treatment. The number rose to 24 when the question related to the time of treatment, but only 14 reported family concern with the adolescent when he or she left treatment.

Among the numerous elements of their lives reported as supporting adolescents after treatment were: certain family members (17), 12-step program participation (15), and non-family adult friends and advisors (16). Among the problems reported in the post-treatment lives of these adolescents, the most numerous responses indicated family problems (28), neighborhood problems (15), and school problems of discipline and attitude (15) and of an academic nature (13).

Twenty-two counselors said families had a history of substance abuse, but only 12 said there was current substance abuse. Sixteen said there was a history of physical or sexual abuse in the family, but only one said there was such abuse in the present. Another problem often reported was current marital difficulties, with 12 counselors indicating such problems exist in the adolescent clients' homes.

COMPARISON WITH CLIENT DESCRIPTIVE STUDY

No Case by Case Analysis Performed in Pilot

In no case was the retrospective parent or adolescent questionnaire linked with the Client Descriptive Study instrument by individual adolescent. This omission was due solely to limitations in the number of retrospective respondents and the time available for analysis.

Because such a comparison would be of great interest in a full outcome study, if one were to be conducted using a retrospective model, a table listing questions from the three pilot instruments that deal with common issues (in Appendix Table 1, pp. 69-71) also lists common questions from the Client Descriptive Study

instrument. This should facilitate such a comparison if such an outcome study were done in the near future.

Pilot Retrospective Totals Compared with Client Descriptive Totals

Even though comparison of the retrospective and Client Descriptive cases was never done, a few proportions have been compared between the 21 total retrospective Pilot adolescents and the 590 total Client Descriptive adolescents. This comparison shows the following:

Table 8

Descriptive Study vs. Retrospective Pilot Study Proportions

QUESTION	CLIENT DESCRIPTIVE STUDY CASES N=590	RETROSPECTIVE PILOT STUDY PARTICIPANTS N=21
Age in years	Mean = 15.7	Mean = 16.5
Sex	Males = 59%	Males = 57%
Race/Ethnic Group	White = 81%	White = 86%
Treatment in Inpatient Facility	IP = 15%	IP = 90%
Family Member with D/A Problems	Yes = 59%	Yes = 23%
Family Participated in Treatment	Yes = 52%	Yes = 67%
Single/No Parent Household	Yes = 65%	Yes = 29%

Clearly, although the two groups seem similar in sex and ethnic group, one would expect the retrospective pilot respondents to be slightly older (since they were interviewed 12-20 months after their assessment and inclusion in the Client Study). Even more striking a difference exists between the modalities of treatment represented, with the pilot's retrospective respondents predominantly from inpatient care. Perhaps most indicative of real distinction between these populations is the fact that more than half of the Client Study cases were from single/no parent households, while this was true of less than a fourth of the pilot retrospective cases.

DATA FROM THE SCHOOLS

Seven schools submitted data on students, four from the prospective and three from the retrospective model. Three adolescents had been at the polled schools throughout the past semester, but four had "other" as response for the question if they had been in that school through the past semester (two of these had been attending alternative schools, one had entered the school only in July, and one had been a home-based student during much of the semester because of a difficult pregnancy).

Grade point average (where 4 was the highest possible) was: .8 and 3.6, and the cumulative average was 1 and 3.9, for those for whom this was given (others did not have this reported). Absences in the spring term were 0, 3, 4, 10, 21, and 30 and tardies ranged from 0 to 6. Conduct reports from the spring term ranged from 0 to 5. Thus, two things learned about the school records search proposed for the outcome study are that almost half the adolescents in school may have attended schools where the measures of progress and record-keeping differ from the usual, and that schools do not appear to object (at least not in this sample) to sharing information by mail, as long as they can see evidence that parents and adolescents wish information to be shared.

Summary

Responses in this chapter are described (mostly) for all respondents, and (for several questions) for respondents by modality, and (for a few questions) by modality and whether the adolescent completed treatment.

This admittedly brief reporting is done because of the small number of respondents, because there was no pre- and post-data on the same persons (as there would be in any outcome study), and because the design of the pilot made the respondents not necessarily representative of the populations at issue. Data given here are anecdotal only.

Responses are discussed for 14 parent questionnaires, for 30 adolescent questionnaires, for 30 counselor checklists, and for the seven data forms received from schools.

CHAPTER 5: CONCLUSIONS AND DISCUSSION

ADVANTAGES OF THE PROSPECTIVE MODEL

The Adolescent Project Pilot for an Outcome Study was conducted in order to determine whether a retrospective outcome study of adolescents would obtain contact rates and participant rates adequate to assure validity, or whether a prospective study would be needed. The pilot found that the name-release rate for a retrospective model (8 of 18, or 44%) was not comparable to such a rate where even part of the family had been in a prospective study, as was the case in the "Mixed" model (with 19 of 27, or 70%, agreeing to name release).

Staff from three agencies attempted to contact 59 clients from the Descriptive Study, assessed in early 1990, and were only able to reach 18 (31%). This indicates that contact rates do not appear to be adequate, either. Furthermore, agency time required to make contacts was excessive, using a retrospective approach (more than twice as much time was required in all, per case, by agencies, for the retrospective situations as for the prospective).

Current clients from another four agencies were also asked for permission to release their names, by the agencies treating them, to test a prospective approach. Response rates were better using this approach, and time demands were less. Even so, travel requirements were considerable, and other time demands also exceeded expectations.

PROCESSES OF THE PILOT SATISFACTORY

The processes of obtaining consent and interviewing participants yielded some interesting results, though only 30 adolescents, 30 counselors, and 14 parents were interviewed. The consent processes worked well. Interviewers reported that most persons with whom they were able to arrange meetings seemed to understand the aims of the study and the assurances of confidentiality from the consent forms. They also seemed pleased to be able to help the project by being respondents.

PROPOSALS FOR INSTRUMENT REVISION

Experience with the three instruments designed for the pilot indicated their current length and construction appear appropriate, overall. The parent questionnaire would benefit from more questions concerning treatment, use, and recovery support needs. The adolescent questionnaire would be improved by questions about initial and later pre-treatment use of drugs and alcohol. Finally, the agency checklist might better focus on pre- and during-treatment questions, omitting or minimizing those that ask about the post-treatment family situation.

The three instruments tested should be revised to be smoother and more easily administered. It would also be advisable to add parts of standard instruments to them to improve their validity and reliability. Two approaches that might be considered for such additions would be to use a hierarchical drug use index (as in Clayton and Voss, 1981) or an index that measures use over time (as the Addiction Severity Index, McLellan et al., 1980). Both indices are cited in Wells, Hawkins, and Catalano (1988); they suggest there is solid precedent for use of the Addiction Severity Index in measuring treatment outcomes.

RESPONSE COMPARISONS

When some of the questions asked of both parents and adolescents were compared, the level of "very similar" responses (according to three out of four interviewers who compared them) was less than 50% for both the prospective and retrospective cases.

In the "Mixed" model (parent-prospective and adolescent-retrospective), there were fewer identical questions (in the agency with this situation, the parent interview consisted of a brief telephone interview conducted by the agency's study staff). Even so, six questions could be compared and three of four reviewers judged 61% of the responses on these six to be "very similar."

One area of major concern was recent adolescent use of drugs and/or alcohol. Consensus between parents and adolescents was far larger with questions concerning this issue, and such agreement ranged from 56% for the prospective group to 79% for the "Mixed" group.

Finally, no case by case comparison has been done between responses on the adolescent or parent questionnaire of retrospective model clients with information on these adolescents at the time they were assessed in early 1990, in the Client Descriptive Study. If a retrospective model outcome study were considered, it would seem advisable to make such a comparison before deciding in its favor. Otherwise, it would not seem warranted by the small number in the sample.

No comparison was done between the responses of the adolescent and/or parent questionnaire of the pilot with the counselor questionnaire, or checklist, in the study. It would seem, as noted earlier, that such comparison might be helpful to any outcome study. Addition of questions to the checklist should consider the advantages of comparability, and might look to increase common questions (see the Common Questions table in Appendix Table 1, on pp. 69-71).

DATA FROM SCHOOLS

School record searches were not actually done in the pilot, since the schools where the study requested data were willing to send their information to the pilot. It appears that information should be obtainable by mail for most outcome study participants who are now or have recently been in school.

It was also learned that grades and absences are frequently reported differently in alternative schools, and that many post-treatment adolescents appear to be in alternative schools. The school data form, consequently, should be revised with assistance from staff in several such schools.

Summary

The pilot study indicates that a prospective (beginning with the early treatment phase) model, with follow-along procedures after treatment, is more efficient and effective for an outcome study of adolescents treated for substance abuse than a retrospective one.

Consent procedures and consent forms that were developed in the pilot seemed to work well. The protocols used for enlisting and training agencies also were apparently appropriate.

Three instruments used by the pilot all need some revision and some additions to make them smoother to administer and simpler to code. Questionnaire changes using parts of some standard instruments would also allow greater comparability with similar populations queried in other places, as well as ensuring greater reliability and validity.

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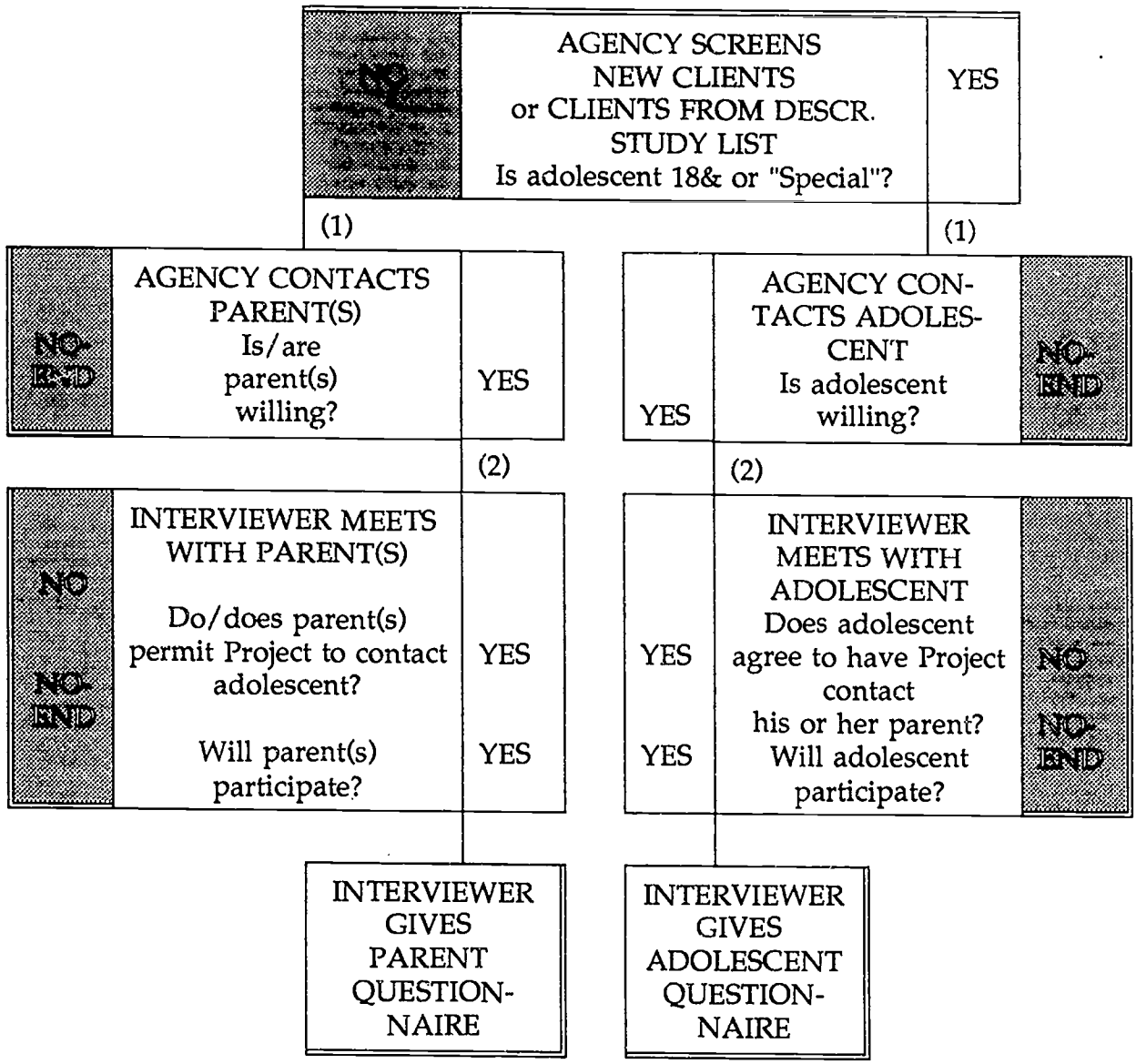
APPENDIX

Appendix Figure 1

Flow Chart of Procedures in Pilot Outcome Study

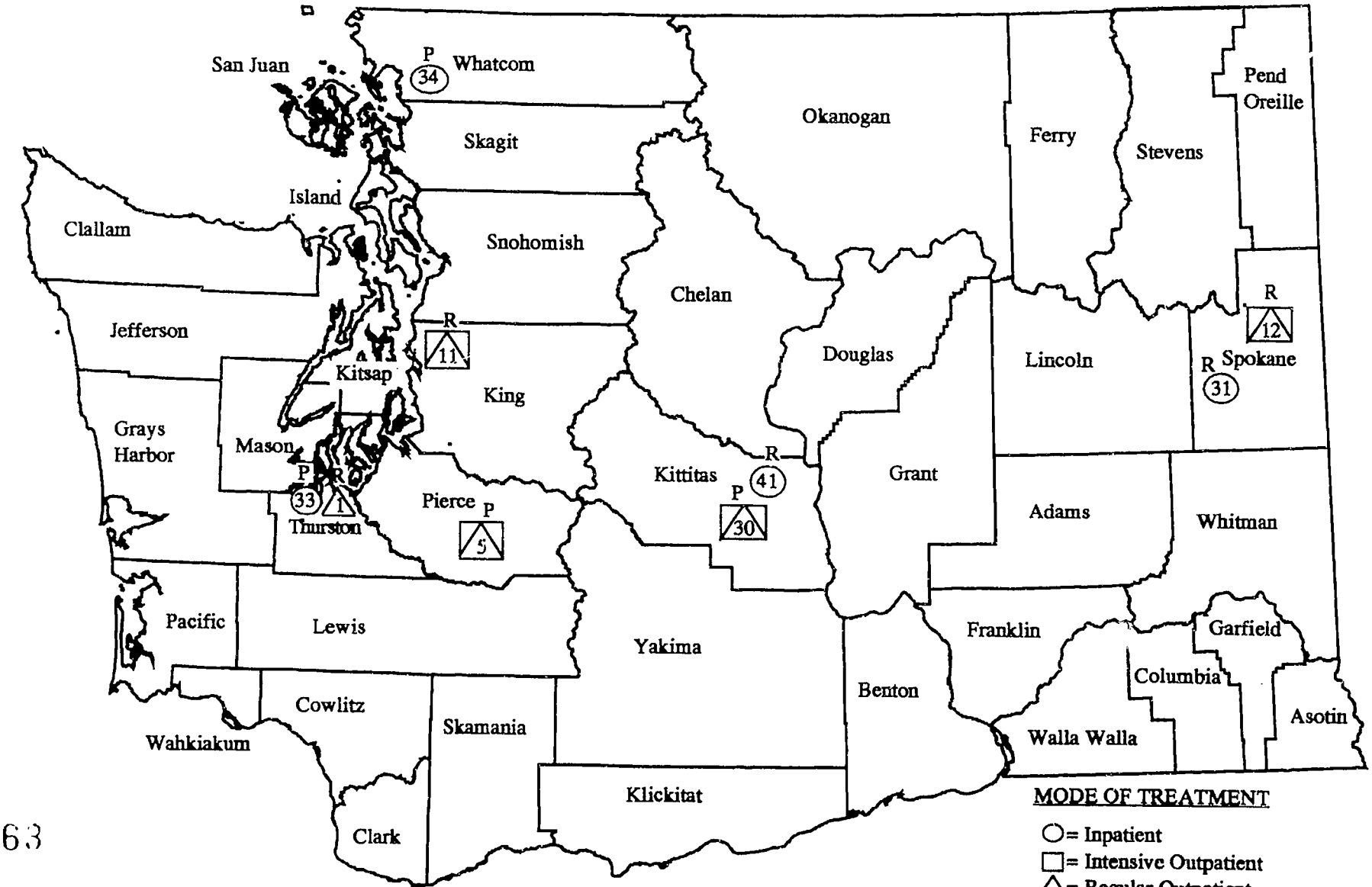


(1) Treatment agency contacts parents (or adolescents as appropriate) to request release of names to the Adolescent Project. (This may be done by telephone or in person, as convenient, but it must be done in private.)

(2) Adolescent Project interviewer meets with parent(s) (or the adolescent as appropriate) to give information about the Pilot Study, and to request consent. With consent, the interview follows, if convenient (it can be scheduled for a later time). If parents consent for Project contact with adolescent, the interviewer will also arrange a meeting with him or her. In the case of the >=18 year-old adolescent and the "Special" adolescent, he or she will be asked if they want the Project to speak with one or both parents. If the adolescent agrees, the interviewer will then contact and inform, and, when consent is given, interview the parent(s).

Figure 2

DIVISION OF ALCOHOL/SUBSTANCE ABUSE ADOLESCENT TREATMENT PROGRAMS IN PILOT OUTCOME STUDY



Note: ORDA agency number is printed inside each symbol.
A list of agencies, by number, follows.

Instruction Packet for Agencies Participating

in

Adolescent Project Pilot Outcome Study RETROSPECTIVE MODEL

Contents:

1. Directions and Explanations

I. DIRECTIONS

Basically, the Adolescent Project Pilot Outcome Study is asking three things of your agency, and none of the three should require a great deal of time.

The first way in which we are asking for your help is in sorting. The second is in obtaining consent to release names, and the third is in sharing information about 10 issues on those adolescents from your agency who agree to participate in the study and who complete our questionnaire.

o Order of procedures - The reason the order is so critical is that we must protect the confidentiality of agency and Department clients, and parental and adolescent rights. Another reason for the critical importance of this order of tasks is that following the procedures exactly will make it easier to get things done in a timely manner, and at minimal cost to your agency.

The Adolescent Project is asking you to follow this order in the tasks:

1) **GET AGES** - Determine adolescent ages, and list those 18 and older.

2) **SELECT "SPECIALS"** - Then find out who are the "Special" adolescents and list these also on your list.

3) **ADD APPROPRIATE PARENT NAMES** - List the names and addresses of parents/guardians of those under 18 who are not "Specials".

4) **PHONE THE APPROPRIATE CONTACT PERSONS (PARENTS OR ADOLESCENTS, AS YOU DETERMINED ABOVE) ON YOUR LIST AND ASK FOR THEM TO PERMIT YOU TO RELEASE THEIR NAMES** - Contact the appropriate persons (parents, usually, or adolescents when 18 or older or "Specials"). If you speak to them on the telephone, we request you follow the suggested "script." If you are speaking to them in person, you'll want to be a bit less formal, probably, but still to cover the same major points. Find out which persons are willing to have their names shared with the Adolescent Project.

5) **MAKE A LIST OF PERSONS - AND THEIR PHONE NUMBERS - WHO HAVE CONSENTED TO ALLOW YOUR AGENCY TO RELEASE THEIR NAMES TO THE PILOT OUTCOME STUDY; HAVE A COUNSELOR OR YOUR AGENCY DIRECTOR SIGN AND DATE THIS "FINAL" LIST.**

II. EXPLANATIONS

Several definitions are very important in the Pilot Outcome Study:

o **Adolescent** - The Division of Alcohol and Substance Abuse defines adolescent as a person 14 through 17 years old, but **for the Pilot Study the Adolescent Project defines adolescent as a 14 through 21 year-old on June 1, 1991.**

o **Descriptive Study Client** - an adolescent who received assessment and/or treatment for substance abuse in early 1990 at your agency, part of whose care was paid for by government, and who was selected to be part of the Adolescent Project Client Descriptive Study.

o **Prospective Pilot** - In this part of the Pilot Outcome Study, **clients who will be asked to participate are those starting treatment at the agency** whose age and funding (PART, at least, of their treatment must be paid for by government) make them eligible and whose parents agree to have their names shared, and to allow the Project to discuss the Study with the adolescent.

Note the two exceptions to the norm of the agency asking parents for permission to share their names: 1) when the adolescent is 18 or older, and 2) when the adolescent has been defined by your agency as a "Special" adolescent. **In these two cases, the agency should ask the adolescent for permission to share his or her name with the Project, and the Project will ask the adolescent if he or she wishes to participate in the study.**

o **Parents** - generally means parents or guardians or temporary custodians such as foster parents.

o **Retrospective Pilot** - In this part of the Pilot Outcome Study, **those asked to participate are Descriptive Study Clients.** The agency will telephone the parents to ask if they are willing to have their names shared with the Adolescent Project, and the Project will ask parents if they allow the Study to be discussed with their children.

There are two exceptions to this rule of the agency asking parents for permission to share their names with the Adolescent Project and of the Adolescent Project asking parents for permission to discuss the project with their children. The exceptions are: 1) when the adolescent is 18 or older, and 2) when the adolescent has been defined by your agency as a "Special" adolescent. **In these two cases, the agency will ask the adolescent for permission to share his or her name with the Project, and the Project will ask the adolescent if he or she wishes to participate in the study.**

o **"Special" adolescents** - are those where the agency determines it is best not to begin contact by asking parent permission to speak with the adolescents 14-17 years old; this is because of the parent's not knowing about the treatment or there being severe problems in the home that mandate asking the adolescent directly. (Persons 18 and older do not need their parents' permission to be in the study.)

2. Procedures

IN THE RETROSPECTIVE MODEL:

I. FIND WHICH ADOLESCENTS ARE NOW 18 AND OLDER

1. For the adolescents on your list, get the PRESENT ages. You will be given a list of Client Descriptive Study persons from your agency. This list will be set up in random order. Please **deal with the list in the order it's in**; do not change the order of the cases. For each person in the list, obtain the age. Do this in the following way: look up the birthdate in the files; write the birthdate on the sample list; beside that, write the age in years as of June 1, 1991.

2. Copy the names of those 18 and older onto the Contact List. Where the client is 18 or older on June 1, 1991, you will attempt to contact the adolescent. (Parental consent is not needed for the Project to be discussed with persons 18 and above.) The names of such adolescents will, then, be at the top of your Sample Contact List. Follow the names by the phone numbers. (If you do not have a separate phone number for the adolescents 18 and older, put the parent phone number on your list.)

3. Cross the names of the 18-year-olds and older off the random order list. Draw a line through those names you have just copied.

II. FIND WHICH ADOLESCENTS SHOULD BE ON "SPECIAL" ADOLESCENT LIST

1. For the adolescents 14-17 years old, list their names and ages on the Adolescent Screening List. Have a counselor or other staff member familiar with the client review the names and/or the file records of these adolescents. This screening review has to consider the following questions:

a) Did the adolescent receive **treatment without the knowledge of either parent?** (If the answer is yes, put the adolescent's name on the "Special" Adolescents List.)

IN THE RETROSPECTIVE MODEL: (cont.)

b) Are there **major unresolved family problems (as, VIOLENCE, SUBSTANCE ABUSE BY PARENTS, SEXUAL ABUSE, etc.)?** (If the answer is yes, put the adolescent's name on the "Special" Adolescents List.)

2. Cross the names of the "SPECIAL" Adolescents off the random order list. Draw a line through those names you have just copied.

3. When you have listed all the adolescents in the "Special" category, write the address and phone number, and proceed with the phone contact attempts (see Procedures for Contacting Parents and "Special" Adolescents").

III. FIND THE NAMES AND PHONE NUMBERS OF THE PARENTS OR GUARDIANS OF THE REMAINING ADOLESCENTS
(those 14-17 not on the "Special" List)

1. **Copy the names of the remaining adolescents onto the Contact List.** Determine with which of their parents they were living as last known to the agency. Write the names of those parents beside the adolescents' names. **(THERE IS ONE EXCEPTION TO THIS RULE: IF ONLY ONE PARENT KNEW THEY WERE RECEIVING TREATMENT, AND IF THAT PARENT IS NOT THE ONE WITH WHOM THEY LIVED, PUT THE NAME OF THE PARENT WHO KNEW BESIDE THE ADOLESCENT'S NAME.)**

2. For each person on the Contact List, determine, as best you can, the **present telephone number.** If the family does not have a phone, see if the files show a message phone. If you cannot find a phone number in the files, call Information and see whether there is a new phone listing for the family. Write the phone number beside the name of the parent(s) on the form.

IV. ATTEMPT TO CONTACT EACH PARENT (OR "SPECIAL" ADOLESCENT) FOR PERMISSION TO SHARE THEIR NAMES WITH THE ADOLESCENT PROJECT

1. Using the list of names and numbers you now have (the Contact List), **phone the appropriate persons to see which are willing to have their names and phone numbers shared** with the Project.

2. When you have obtained all possible consents, copy consenters to the "Final" list, and have the Agency Director or a lead counselor sign and date that form. Make a copy for your files. Give the original to the Adolescent Project interviewer.

3. Suggested Telephone "Scripts"

A. Telephone Script for RETROSPECTIVE

Treatment Agency use in contacting parents to ask permission to give their names and telephone numbers to the Adolescent Project

o Hello, Mr./Ms._____. This is _____ from _____ treatment center. You may remember that we worked with your son (or daughter) _____, last year.

o We work hard to protect the confidentiality of our clients, and that is why I am calling you now. The Adolescent Project is a research project, working in the Office of Research and Data Analysis in the Department of Social and Health Services. It is a project working to find out how to better help young people with substance abuse problems. That project has asked our agency to give them some names of parents of young people we served last year, so that they may ask the parents if they are interested in being part of a research study and if they will allow the research study to also talk to their child who was treated about being part of the study.

o Are you willing for us to give this project your name(s) and telephone number so that an interviewer from the project could talk with you about their research study? You do not have to do this, and if you talk with them you do not have to agree to be part of the study.

o Alright, Mr./Ms. _____. I will/will not, as you wish, give your name and phone number to the Adolescent Project. Thank you for taking time to speak with me today.

B. Telephone Script for RETROSPECTIVE

Agency use in contacting "special" adolescents and those 18 and older
to ask if their names may be shared with the Adolescent Project

o Hello, _____. This is _____ from _____ treatment center. We worked with you last year.

o We work hard to protect the confidentiality of our clients, and that is why I am calling you now. The Adolescent Project is a research project, working in the Office of Research and Data Analysis in the Department of Social and Health Services. It is a project working to find out how to better help young people with substance abuse problems. That project has asked our agency to give them some names of young people we served last year, so that an interviewer from the project can talk with them about whether they want to be part of a research study.

o Are you willing for us to give this project your name(s) and telephone number so that an interviewer from the project could talk with you about their research study? You do not have to do this, and if you talk with them you do not have to agree to be part of the study.

o Alright, _____. I will/will not, as you wish, give your name and phone number to the Adolescent Project. Thank you for taking time to speak with me today.

4a. CONTACT LIST - Agency Name: _____

PART I: 18 YEAR-OLDS AND OLDER:

Name of Adolescent	Phone Number	Date Contacted	Yes or No?

PART II: "SPECIAL" ADOLESCENTS: 14-17 year-olds; contact should begin with them rather than their parents, because of parents not knowing about treatment, adolescents not living with parents/guardians, or because of other complex situations where we believe it is in the adolescent's best interest not to contact his or her parent(s) first to ask permission to discuss a research project with the adolescents.

Name of Adolescent	Phone Number	Date Contacted	Yes or No?

PART III: PARENTS OF 14-17 YEAR-OLDS NOT ON "SPECIAL" ADOLESCENT LIST:

Name of Adolescent	Phone Number	Date Contacted	Yes or No?

4b. FINAL CONTACT LIST - Agency Name: _____

ALL THE PERSONS BELOW HAVE AGREED TO RELEASE OF THEIR NAMES

PART I: 18 YEAR-OLDS AND OLDER:

Name of Adolescent Phone Number

_____

_____

_____

PART II: "SPECIAL" ADOLESCENTS: 14-17 year-olds; contact should begin with them rather than their parents, because of parents not knowing about treatment, adolescents not living with parents/guardians, or because of other complex situations where we believe it is in the adolescent's best interest not to contact his or her parent(s) first to ask permission to discuss a research project with the adolescents.

Name of Adolescent Phone Number

_____

_____

_____

_____

PART III: PARENTS OF 14-17 YEAR-OLDS NOT ON "SPECIAL" ADOLESCENT LIST:

PARENT NAME Adolescent Name **Parent** Phone Number

_____

_____

_____

_____

_____

_____

_____

(signed) **(position in agency)** **(date)**

PILOT PROJECT CONSENT FORM - Adolescent (prospective)

INVESTIGATOR'S STATEMENT

- **WHAT IS THIS PROJECT, AND WHO IS DOING IT?**

  This is a pilot project for a larger outcome study to be begun in September of 1991.. We are doing the pilot and the later outcome study to look at how young persons' lives are affected by alcohol/drug treatment. The project is being done by the State's Department of Social and Health Services.

- We are asking you to help us by talking with us, answering questions in a questionnaire that will take about an hour today, about what's going on in your life. We got your family's name from the treatment program you are participating in. Your family gave us permission to contact you, to ask if you would be willing to be part of our pilot study. We plan to talk with about 100 adolescents like yourself, who used treatment services last year or this year, in this pilot study.

- **WE ARE INTERESTED IN TALKING WITH YOU, IN THE QUESTIONNAIRE, ABOUT FOUR TOPIC AREAS:**

  - Your background,
  - Any alcohol or drugs you may recently have used
  - How you get along with your family, and
  - How you are doing in school.

- If you agree to be in the Pilot Outcome Study, we will also ask a counselor at the treatment center to answer a few questions about you.

- We are also asking your permission to look at your school records, in order to get information about your grades, attendance, and conduct reports, if any. No mention of your treatment or similar matters will be made to your school.

This is a voluntary and confidential study

- You do not have to talk to us. We are asking you to volunteer to help us by answering our questionnaire. Refusal to participate will involve no penalty or less of benefits to which you are otherwise entitled. If you agree to be in this study and answer the questions in our questionnaire, you still don't have to answer any particular question. You may refuse to answer any question or stop being part of the study at any point.

ADOLESCENT CONSENT FORM (CONT.)

- Everything you tell us and all information from your family, treatment counselor, school records, and even your name is completely confidential. We have signed a promise not to tell anything we may find out about you to your family, treatment agency, legal authorities, or anyone else. No one can find out what you tell us except in the one situation explained below.

- If we have reason to suspect that any person may physically or sexually abuse someone, or has abused someone, or is planning suicide, we are required by law to report this information to the Department of Social and Health Services.

Risks and Safeguards

Any risk to you from being part of the study would be related to either a failure in the Adolescent Project's confidentiality procedures or your feelings about discussing your situation. We have committed our research project and all of our staff to the protection of your confidentiality. You are free to not respond to questions that are uncomfortable for you. When you complete the questionnaire, we will remove the top page from it, and keep your name and all identifying information under lock and key at all times, and separate from what you have told us.

Benefits

The Adolescent Project Pilot Outcome Study will help the Project decide how to conduct a large outcome study in the fall of 1991. That study will help your state government and the state's treatment agencies to fund and manage better treatment programs for adolescents. Your participation now will be an important part of our efforts to improve treatment for adolescents with drug or alcohol-related problems.

To show our appreciation for your time and sharing we are also offering you a choice of gift certificates, redeemable for records, tapes, books, or clothing.

Do you have questions about any part of the Pilot Outcome Study?

If you want additional information, feel free to contact either Jenny Louden or Dario Longhi at (206) 586-1431. You may **CALL COLLECT**.

_____

(Jenifer H. Louden, MA, MPA, Director) (Dario Longhi, PhD, Director)

I have read the above statement to the adolescent.

_____

(signature of Adolescent Project interviewer) (date)

ADOLESCENT CONSENT FORM
ADOLESCENT SIGNATURE PAGE

SUBJECT'S STATEMENT:

The following facts have been explained to me. I understand what they mean.

- o I know that the Adolescent Project is a state run research project to find out how adolescents are affected by drug and alcohol treatment programs.
- o I understand that the Adolescent Project wants to talk with me about 4 topics: My background, my use of drugs and/or alcohol, how I get along at home, and how I get along in school or at work. I will participate in an interview that will take about an hour to complete.
- o I am clear that my participation is voluntary and that not participating or stopping my participation will not in any way affect any of my benefits.
- o I know that all information I give the Project, with the exception of information about a person hurting someone, will be kept confidential.

CONSENT:	**CHECK TO SHOW AGREEMENT:**
I agree to talk with an interviewer from the Adolescent Project about the topics noted above	____ I agree

Adolescent's Name
(Printed)_____

Address_____

City_____ Phone _____

Adolescent signature: _____
(date)

Interviewer's signature:_____
(date)

ONE ORIGINAL EACH TO PARTICIPANT AND ADOLESCENT PROJECT FILES

ADOLESCENT CONSENT FORM

ADOLESCENT SCHOOL SIGNATURE PAGE

CONSENT

CHECK TO SHOW AGREEMENT OR NOT

I give my permission for the Adolescent Project to examine my school records. ____ Yes ____ No

Adolescent's Name (Printed)_____

Address_____

City_____ Phone _____

Adolescent's signature _____
(date)

ONE ORIGINAL EACH TO PARTICIPANT AND TO SCHOOL
COPY TO ADOLESCENT PROJECT FILE

Appendix Table 1

Common Questions in Adolescent Project Questionnaires of Client Descriptive Study and Pilot Outcome Study

TOPICS	CLIENT DESCRIPTIVE	PILOT - ADOLESCENT	PILOT - PARENT	PILOT - COUNSELOR
DEMOGRAPHICS:				
Identifiers (name, address, etc.)	cover sheet	cover sheet	cover sheet	ID# only
Age, Birthdate of adolescent	6, 6a	83, 84	none	none
Sex of adolescent	130	95	63	none
Race/Ethnic Group (respondent)	131	85, 86	54, 55	none
First language (respondent)	132, 133	87, 87a	56, 56a	none
Persons Adolescent Lives with	15, 46	1a-q	1a-q	none
RELATIONSHIPS, GENERAL:				
With Friends	none	19, 20	52	none
With Boy/Girlfriend (significant other)	none	21, 22	none	8e
Social Skills	none	none	51	none
Most Important Persons	48, 48a	10a-10c	none	none
Gang Involvement	43	73	none	none
RELATIONSHIPS, FAMILY:				
Relations with Siblings	45	none	11, 12	none
Family Moves/Adjustments to Moves	none	none	21,22	none
Relations Between Adolescent & Family	45-45b	2a-h, 3, 3a, 9	28	none
Control of Temper at Home	none	8	26-28	9
Family Functioning, General	61-62	none	2, 3, 5, 9	7a, 8d, 9a-9i
Participation and Helping at Home	none	17-18a	6-8, 19-20	none
Emotional Needs Met at Home	none	none	13	5c
Major Decision-Maker in Family	none	none	4	none
Par.Communication/Relating to Adolescent	none	none	15-17	none
Par.Feelings about Adolescent's Friends	none	none	52	none
Difficulties in home (Hist./current abuse)	none	none	none	9a-9i

Appendix Table 1 (continued)

Common Questions in Adolescent Project Questionnaires of Client Descriptive Study and Pilot Outcome Study

TOPICS	CLIENT DESCRIPTIVE	PILOT - ADOLESCENT	PILOT - PARENT	PILOT - COUNSELOR
PROBLEMS/NEEDS OF THE FAMILY:				
Family Members' Drug/Alcohol Problems	16b-d	53, 54a-i	none	none
Family Use of Public Assistance/Services	64, 64a-g	88-89	57-58	none
PROBLEMS/NEEDS OF ADOLESCENT:				
Legal System Involvement	20a-b, 86, 8c	70a-f, 77	none	none
Property Crime Committed	none	72	none	none
Driving Infractions, DWI	none	74-75	none	none
Other Illegal Activity	none	76	none	none
Arguments, Emotional Behavior	none	8	26-28	none
Physical, Mental, Emotional Health	52-54, 58-60	none	44-46	none
Use of Violence/Threats	none	71	none	none
Adolescent Runaway/Overnight AWOL's	47, 72	5-7	23-25	none
Troubled Areas/Negative Influences	none	none	none	8a-8k
FEELINGS OF ADOLESCENT:				
Self-Esteem	none	none	48	none
Happiness	none	none	49	none
Control over Own Life	none	55-56	none	none
Use of Leisure Time & Other Resources	none	none	50-53	none
Sources of Support	none	none	none	7a-7k
ADOLESCENT SUBSTANCE USE:				
Use--what, when, how much?	21a-21b	42-48	41-43	none
Problems with Substance Use	none	50	none	none
Past IV Use	44	49	none	none
Problems Staying Clean & Sober	none	78-79	none	none

81

82

Appendix Table 1 (continued)

Common Questions in Adolescent Project Questionnaires of Client Descriptive Study and Pilot Outcome Study

TOPICS	CLIENT DESCRIPTIVE	PILOT - ADOLESCENT	PILOT - PARENT	PILOT - COUNSELOR
D/A TREATMENT OF ADOLESCENT:				
Treatment History, Frequency, Modality	13, 22-27, 73	23-27, 29-30	none	1-2
Treatment Ended	28, 102	28	none	1
Aftercare - What sort?	29, 31, 80	37	none	6
Aftercare - Attendance/Frequency	83-85	38, 40	none	6
Aftercare - Completed?	86	39	none	none
Was Treatment Appropriate and Effective?	68-69, 92	32-33a	36	4
Feelings about Treatment	none	31	none	3
Assault/Other Interpersonal prob's in Tx	78-79	none	none	none
Family Participated in Treatment	76-77c	34-35d	37-38d	5a-5b
Treatment Readiness and Effects	none	31-32	55	3-4
SUPPORTS FOR/IN RECOVERY:				
12-Step Program Involvement	none	57-61	none	10a-10g
Supported by Others in Recovery	none	80	none	5a-5c, 7
Support of Important Family& in Recovery	49-50	11-16	none	5a-5c, 7
What Else Needed to Stay Clean?	none	81	none	none
Other Services Needed Besides/After Tx	70-71g	41, 82	39-40d	none
SCHOOL, WORK:				
Adolescent in School?	18, 87a	62	29-29a	none
School Name, Location	18a, 51	64,66	30a-30b	none
Grades/Schoolwork Satisfactory?	18b	none	34	none
Feelings about School	38	63	none	none
Performance/Attendance Problems	51c	65, 68, 68a	31-34	none
Ability to Learn	55-56	none	47	na

Appendix Table 2
Comparison of Adolescent and Parent Questionnaire Responses in 14 Matched Cases with Inter-Rater Agreement* among Four Interviewers Who Reviewed Responses

Question/Issue**	Very Similar (A-P) answers+		Somewhat Similar (A-P) answers+		Very Different (A-P) answers+		Other/Not Comparable answers	
	P	R	P	R	P	R	P	R
Emotional Behavior at Home (8;27,28)	2	2	2	1	3	0	0	0
Problems Getting Along at home (3;5,10,12)	2	3	2	2	1	0	0	0
With whom Living Now (1,1)	2	2	4	0	0	1	1	0
Does Chores at Home (17,18a;20)	3	1	2	2	2	2	1	0
Gone Overnight w/o Permission (5,23)	5	4	0	0	3	0	1	1
# Overnights w/o Permission (6,24)	1	1	1	1	3	0	4	3
Ran Away recently (7,25)	8	4	0	0	0	0	1	1
Family Receiving Public Services (88,57)	7	4	0	0	2	0	0	1
Services Received (89,58)	3	1	0	1	1	0	3	3
Subtotal Family Issues	33	22	11	7	15	3	11	9
+Treatment Effectiveness (32,36)		2		0		2		0
+Family Participated in Treatment (34,37)		5		0		0		0
+Who Participated in Treatment (35,38)		2		2		0		1
+Needed Services plus Treatment (41,39)		1		1		2		1
Subtotal Treatment Issues		10		3		4		2
Drug/Alcohol Use (42,41)	6	3	0	1	2	0	1	1
#Times D/A Used (43,46;42)	4	3	1	0	2	0	2	2
Subtotal Drug and Alcohol Use Issues	10	6	1	1	4	0	3	3
In School (62,29)	7	4	0	0	0	1	2	0
School Attendance (65,31)	2	0	0	0	0	1	6	4
School Problems (68,32)	3	1	0	0	2	1	4	2
Seriousness of School Problems (68a,34)	2	0	1	0	0	1	5	4
Work (67,35)	5	3	1	0	2	2	1	0
Subtotal School and Work Issues	19	8	2	0	4	6	18	10
Total In All Questions (16P, 20R)	62	46	14	11	23	13	32	24
Possible Responses++	144	100	144	100	144	100	144	100
Total as Percent of Possible Responses:	43%	46%	10%	11%	13%	13%	22%	24%

*Only those responses where 3 or more of the interviewers agreed, in separate reviews of the data, are reported here. For several questions, especially those about school problems, interviewers agreed that responses could not be classed as either agreeing or disagreeing, and these are in the "Other/Not Comparable column."

**Numbers following the question/issue are those of the Adolescent (first number) and Parent questionnaires. Appendix Table 1, on pp. 58-60, lists these and other similar/identical questions.

+These 4 questions were asked only of retrospective cases, as they ask about treatment situation of the previous year.

++The first number in each column is that of the prospective cases (of the total of 9 such); the second is the number of the "purely" retrospective cases (of 5 such).

Number total possible Prospective responses = 144 (9 cases x 16 questions)

Number total possible "Pure" Retrospective responses = 100 (5 cases x 20 questions)

Appendix Table 3

Comparison of Adolescent Questionnaire and Parent Phone Responses in 12 Matched Cases with Inter-Rater Agreement* among Four Interviewers Who Reviewed Responses

Question/Issue**	Very Similar (A-P) answers+	Somewhat Similar (A-P) answers+	Very Different (A-P) Answers+	Other/Not Comparable Answers
Problems getting along at home (8,9-11)	8	0	1	0
With whom Living Now (1,8)	5	2	0	0
Subtotal Family Issues	13	2	1	0
Drug/Alcohol Use (42,15)	10	0	1	1
#Times D/A Used (43,46;15)	9	1	1	1
Subtotal Drug/Alcohol Use Issues	19	1	2	2
In School (62,4)	7	0	1	4
Work (67,6)	5	3	2	1
Subtotal School/Work Issues	12	3	3	5
In All Comparable Questions (6 semi-R)	44	6	6	7
Percent of Possible Responses##	61%	8%	8%	10%

* Only those responses where 3 or more of the interviewers agreed, in separate reviews of the data, are reported here. For several questions, especially those about school problems, interviewers agreed that responses could not be classed as either agreeing or disagreeing, and these are in the "Other/Not Comparable column."

** Numbers following the question/issue are those of the Adolescent (first number) and "Mixed" model (Daybreak of Spokane) telephone questionnaires (second number).

Total Possible "Semi" Retrospective Responses = 72 (12 cases x 6 questions)

Appendix Table 4

Respondents' Choices of Gift Certificates in Pilot Outcome Study

AGENCY	CLOTHING	MUSIC	BOOKS	TOTAL
A	0	2	1	3
B	0	3	0	3
C	3	0	0	3
D	0	1	0	1
E	2	0	0	2
F	2	8	2	12
G	0	1	2	3
H	1	1	0	2
TOTAL	8	16	5	29

Note: One participant refused to accept a gift certificate.

Appendix Table 5

Responses by Whether Adolescents in Pilot Study Completed Treatment

QUESTION/INSTRUMENT	PROSPECTIVE-COMPLETE (N=7)	PROSPECTIVE-INCOMPLETE (N=2)	RETROSPECTIVE-COMPLETE (N=15)	RETROSPECTIVE-INCOMPLETE (N=6)
ALCOHOL/DRUG USE and RECOVERY:				
No use (A#42;N=30)	5	1	9	3
No use (P#41;N=14)	4	2	1	1
Only one time use (A#43)	0	1	1	1
Only one time use (P#42)	1	0	0	0
12-Step meeting attended (A#57)	6	1	5	2
More control over life than before tx (A#55)	6	2	13	5
FUNCTIONING, IN FAMILY and SOCIETY:				
Adolescent gets along fair or better (P#5)	5	1	4	1
Fair or better relationship with household members (A#2b,d,f,h)	7	2	14	6
No overnights out without permission (P#23)	3	1	2	1
No overnights out without permission (A#5)	5	1	9	5
No involvement with any part of legal system (A#70a)	3	1	4	2
No use of violence or threats (A#71)	5	1	11	3

88

89

Appendix Table 5 (continued)

QUESTION/INSTRUMENT	PROSPECTIVE-COMPLETE (N=7)	PROSPECTIVE-INCOMPLETE (N=2)	RETROSPECTIVE-COMPLETE (N=15)	RETROSPECTIVE-INCOMPLETE (N=6)
FAMILY INVOLVEMENT AND SUPPORT:				
Any family member using (A#53)	5	1	10	4
Family member use a problem (A#54c,f,i)	3	1	2	1
Family member current abuse (C#9h;N=30)	5	1	4	2
Family involved and supportive before, or in, or after, treatment (C#5a,b,c)	3	1	10	3
Do important people support your staying off A/D? (A#11,13,15)	7	2	14	5
GETTING ALONG AT SCHOOL OR WORK				
Adolescent in school last quarter (A#62)	5	0	11	5
Adolescent in school last quarter (P#29)	5	0	1	1
Doing average or better in school (P#34)	1	0	0	0
Adolescent working full or part-time (A#67)	0	1	7	4
No problems with school or work (A#68)	2	1	11	2

Notes: Completed treatment is defined in this table by whether the counselor stated (in the Agency Checklist, or counselor interview) that the adolescent had either completed one or more treatment programs or was near completion of at least one program.
This is a broader definition of completion than that used in the Adolescent Client Descriptive Study.
Instruments are as follows: A=Adolescent Questionnaire; P=Parent Questionnaire; and C=Counselor interview (Agency Checklist).
There were 30 respondents in the adolescent and counselor instruments, but just 14 in the parent interview.
All of the numbers listed immediately after the instrument letters are numbers of the questions in those instruments.

Appendix Table 6

Problems Encountered and Suggested Strategies from the Pilot Outcome Study

Problems Encountered	Probable Causes	Suggested Strategies
INITIAL PROCESSES--AGENCIES		
Obtaining enough names of persons willing to have agencies release them	- in retrospective model, time lapse - in prospective model, not really any	Use prospective model for future outcome study.
INITIAL PROCESSES--INTERVIEWERS		
Reaching persons, by telephone, who agree to name release, to make appointments for meetings	- work and school hours vary	Have interviewers phone at various times, including evenings.
Some respondents were late to, or forgot, appointments with interviewers	- people forget easily	Have interviewers phone reminders, on day of appointment.
INTERVIEWING STAGE		
Many trips and travel, costly in time and dollars, were required	- inpatient treatment clients come from a wide variety of places	In actual study, sort respondents by residence area so consent/interview procedures are grouped by areas of residence.
School responses were not complete, from alternative schools	- record-keeping is different in alternative schools	Meet with staff members from various schools to revise school data form.